

People at risk of homelessness: A qualitative study of housing
support initiatives

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STATEMENT OF AUTHORSHIP

DECLARATION OF ORIGINALITY

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STATEMENT OF ETHICAL CONDUCT

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines by the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University.

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PUBLICATIONS

There are three publications arising from this thesis. These are presented below. As a PhD candidate, I took full responsibility for ethical approval, data collection/analysis and preparation of drafts. My supervisors and collaborators (co-authors) provided feedback and guidance with final manuscript and report preparation.

Publications relating to the Maintenance Support Program

McMaster, R., Lopez, V., Kornhaber, R. & Cleary, M. (in press, 2017). A qualitative study of a Maintenance Support Program for women at risk of homelessness: Part 1: Personal factors. *Issues in Mental Health Nursing*. Accepted 5 February 2017. DOI: <http://dx.doi.org/10.1080/01612840.2017.1292570>

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McMaster, R., Lopez, V., Kornhaber, R. & Cleary, M. (in press, 2017). A qualitative study of a Maintenance Support Program for women at risk of homelessness: Part 3: Societal factors. *Issues in Mental Health Nursing*. Accepted 5 February 2017. DOI: <http://dx.doi.org/10.1080/01612840.2017.1292572>

ABSTRACT

Homeless people tend to have a number of complex medical healthcare needs sometimes exacerbated by mental illness and substance use disorders. A number of diverse programs and services are available for people who are at risk of homelessness, many of which have not been researched, particularly from clients' and service providers' perspectives. This qualitative descriptive study was informed by the conceptual framework of Social Cognitive Theory, which was used to explore a Housing Support Program (HSP) from the perspective of the clients, case managers and housing support professionals. A Maintenance Support Program (MSP) from the perspective of clients, case managers and health professionals was also investigated. Interviews and focus groups were conducted, and data were analysed using thematic analysis. Two major themes emerged.

The major theme from the HSP data provided a positive overarching theme of "A life-changing event: I now have a home" for the client with three sub-themes comprising of: continuity of care, bridging the gap, and inclusion in the world. The clients described their experience as a positive one related to the assistance of the supportive case managers. The health professionals reported that the HSP is an organisation that provides a holistic approach to caring for the clients that is different from other agencies or services that are provided by both non-government and government organisations.

The overarching theme that emerged from the themes and subthemes from the client data in the MSP study was "A life-changing event: I have the power to change" also consisting of three sub-themes: personal, situational and societal

dimensions. This life-changing event resulted from the clients' experience of both enabling and constraining factors and this led to a feeling of power to change towards a better future. The enabling and constraining factors worked together to influence, develop and maintain the many themes of a life-changing event. At times, the constraining factors outweighed the enabling factors. In this case, the clients maintained or returned to a state of instability that limited or minimised their ability to have the power to change. The enabling aspects on the other hand provided the client with a sense of self, of movement, power and of a new beginning.

This study contributes to new knowledge concerning the experience of people in a HSP and a MSP who are homeless or at risk of homelessness. Through the involvement of case managers and health professionals within these programs, a life-changing event occurs. Clients within the HSP and MSP had the time to reconsider and review their lives, and are able to develop a sense of future. The findings provide insight into the constraints and enabling factors, as well as the dimensions and outcomes related to homeless support programs which could further improve the services provided to this vulnerable population

CHAPTER 1: INTRODUCTION

1.1 Introduction

Homelessness is seen as the state or condition of having non-permanent accommodation, no home or place that is secure, safe and connected with society (Flatau & Zaretsky, 2013; Homelessness Australia, 2016). Similarly, homelessness has been described as an experience that alters an individual's sense of place, of self and of belonging (Vandemark, 2007). The subject of homelessness creates distress in society as it is immersed in prejudice and stereotypes (Inzlicht, Tullett, Legault, & Kang, 2011). The reasons and consequences of being homeless have been studied although conflicting viewpoints exist on what establishes homelessness, who are the homeless, and who has responsibility for ending homelessness. Dialogues and debates concerning these issues will help better understand the plight of homeless people so as to develop appropriate interventions (Chamberlain, Johnson, & Robinson, 2014). Definitions of homelessness vary according to the perspectives of objectivists or subjectivists. Objectivists view homelessness with an emphasis on the housing structure, while subjectivists are interested in the personal meaning of living spaces, taking into account individual's perception of homelessness (Chamberlain et al., 2014).

People who are homeless or who are at risk of being homeless are not a homogeneous group. The length of time they are homeless varies as well

as the type of assistance sought (Scutella, Johnson, Moschion, Tseng, & Wooden, 2013; Statistics, 2012). Many services provided to the homeless focus on subsistence which is adequate enough to sustain their basic needs (Belcher & DeForge, 2012). Housing tenancy and support can partially address these needs, but people who are at risk of homelessness have further challenges, these include accomplishing goals within complex and changing life circumstances. Multiple complex needs include health, psychological and social needs (Cave, Fildes, Luckett, & Wearing, 2015; Commonwealth of Australia, 2008; Hwang & Burns, 2014). Reviews of programs have shown the benefits of integrated services for people who have complex needs and highlight case management as a core component which can facilitate a unified approach to service delivery (Flatau & Zaretzky, 2013).

In this chapter a background to the study is provided, initially the focus is on homelessness including demographics, government policies and responses. Secondly, the services provided for people who are homeless or who are at risk of homelessness are discussed. Finally, the aim and objectives of the study and the potential significance of this study will then be enunciated. The structure of the thesis forms the conclusion to the chapter.

1.2 Background

The definitions of homelessness differ between countries depending on legislation and specific criteria employed for assessment, this makes homelessness a difficult and complex situation to measure (Australian Bureau of Statistics, 2011). The United Nations Commission on Human Rights estimates that over 100 million people worldwide are homeless, with 1.6 billion living in inadequate shelter (Edgar, Harrison, Watson, & Busch-Geertsema, 2007; Habitat for Humanity, 2015). People at risk of homelessness is growing in Australia and overseas. Since 2008, homelessness has increased within the majority of the European Union Member States (European Commission, 2013). In the United States of America, the number of people sleeping on the streets has declined since 2007 although the number of people sleeping in emergency shelters has increased, while people living in overcrowded housing has doubled (Henry, Shivji, de Sousa, & Cohen, 2015). On one-night in January 2013 an estimate of 610,042 individuals were homeless in the U.S. (Solari et al., 2014). In England from 2009 to 2010, there was an increase of thirty seven percent of people considered homeless, including those living in insecure and overcrowded housing and on the streets (Fitzpatrick, Pawson, Bramley, Wilcox, & Watts, 2015).

In Australia, there was an increase of 8% in the homeless population from 2005 to 2011. One hundred and five thousand people were considered

homeless (Australian Bureau of Statistics, 2012). The reasons for the increase in people who are homeless are multifaceted. In Australia and internationally, the reasons include economic and financial problems caused by unemployment and lack of affordable housing (European Commission, 2013; Statistics, 2012).

Homelessness is a collective societal problem, and people who are homeless are often treated as society's underclass, stigmatised and excluded (Belcher & DeForge, 2012). More recently, homelessness has been seen as an interaction between social and economic structures together with individual factors (Fazel, Geddes, & Kushel, 2014; Johnson & Jacobs, 2014; Johnson, Scutella, Tseng, & Wood, 2015). Social structural factors include the deinstitutionalisation of the mentally ill (Fazel et al., 2014; Johnson & Jacobs, 2014; Shinn, 2007). Economic structural factors include lack of affordable accommodation, poor employment prospects for low skilled workers, lack of income support together with income inequality (Fazel et al., 2014; Johnson & Jacobs, 2014; Shinn, 2007). These structural factors and individual limitations can compound an individual's vulnerability to physical and mental health problems, substance use issues, association with the criminal justice system and individual traumatic experiences (Fazel et al., 2014; Johnson & Jacobs, 2014).

Other factors that an individual has no control over, such as age, gender and ethnicity and the issue of agency, (referring to an individual's

independent decision making or choice), can impact on people who are homeless or at risk of being homeless (Johnson et al., 2015).

1.3 Government policy in Australia

In Australia over the past decades, groups of people identified as homeless and having multiple needs include: women leaving domestic violence situations, young people leaving dysfunctional home environments, displaced older people, as well as families with children, the working poor and older single women unable to afford housing (Chamberlain et al., 2014). Thus, governments at both the state and federal levels have been challenged to adequately address the issues and needs of the homeless population (Australian Institute of Health and Welfare (AIHW), 2015).

In response to the growing problem of homelessness, the Supported Accommodation Assistance Program (SAAP) commenced in 1985. Sub-programs within this program included General Supported Accommodation Program for services to all homeless men, women and dependents; Women's Emergency Services Program which support women and dependent children leaving domestic violence situations; and Youth Supported Accommodation Program for people between 12 and 24 years of age (Coleman & Fopp, 2014).

In 2007, a raft of new proposals for homelessness was outlined in White Paper; "The Road Home: A national approach to reducing homelessness" (Commonwealth of Australia, 2008), and in 2009, SAAP was subsumed

into the National Affordable Housing Agreement (Coleman & Fopp, 2014). Specialist housing, health and support services which involved assessing client's specific needs, connecting them with other services as needed, negotiating with these services and managing service delivery were identified as being necessary. In the White Paper the importance of providing specialist services which "wrap services around their clients" who are homeless or at risk of homelessness as necessary components of a prevention and intervention service was identified (Commonwealth of Australia, 2008, p. 47). Included in these "wrap around" services are the use of effective case management (Commonwealth of Australia, 2008, p. 15). Case management involves responding to the individual needs of clients to enhance self-care, self-determination and independence whilst working in partnership with specialist and mainstream services (Specialist Housing Support in Housing NSW, 2012).

Case management approaches involve coordination of individual client care and community-based health promotion (Maijala, Tossavainen, & Turunen, 2015). Within the specific context of homelessness, case management has a positive outcome of health improvement and psychosocial functioning for the clients. Moreover, community-based health promotion incorporating early intervention, assessment of individual needs and preparation of the client within a trusting relationship with staff has been shown to offer positive outcomes (Coles, Themessl-Huber, & Freeman, 2012).

Following *The Road Home Report*, the National Partnership Agreement on Homelessness (NPAH) (Commonwealth Government of Australia, 2008) was commenced in 2009. Strategies were implemented to support the reduction in homelessness, including, early intervention and prevention, breaking the homeless cycle and improving services through the provision of annual funding programs (Homelessness Australia, 2016). Complementing these strategies, the Council of Australian Governments (COAG) commenced the National Affordable Housing Agreement where the Australian Government provides leadership for the prevention and reduction of homelessness by targeting specific program activities annually (Department of Social Services, 2016).

There have been several programs implemented by both government and non-government organisations to assist with housing, health and support for people at risk of homelessness (Australian Housing and Urban Research Institute, 2015; Fitzpatrick-Lewis, Ganann, Krishnaratne, Ciliska, Kouyoumdjian, & Hwang, 2011; Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005). These include programs aimed at improving outcomes, for people leaving mental health facilities, prison, institutional care, rough sleepers, Indigenous Australians and domestic violence interventions for women with children (Homelessness Australia, 2016). Very few of these specialist programs have been studied particularly from the perspectives of the clients, case managers, housing support professionals and health professionals (Costello, Thomson, & Jones, 2013; Flatau et al., 2006).

Studies recently conducted in Australia examined the cost-effectiveness of tenancy support programs (Zaretzky & Flatau, 2015). In this quantitative study, the clients who had support from homeless support programs were more likely to keep their tenancies and therefore occupancy, than those who had not received support. Another evaluation study measured the propensity of the homeless population to move locality when accessing specialist homelessness services in Australia (Conroy, Zezovska, Shah, & Kynaston, 2015). Findings demonstrated that clients were relocated into the inner city (by other service providers) where services and expertise was considered to be available for clients with complex needs (Conroy et al., 2015).

1.4 Local responses to homelessness in NSW

One local response in Sydney to the National Homeless Strategy funded through the then Department of Families, Housing, Community Services and Indigenous Affairs was the implementation of a Housing Support Program (HSP). This HSP was established, through a non-government organisation, as a case management / community care model where support was offered to those, who were at risk of eviction from their homes. The HSP target group comprised adults, 45 years of age or older, who had been recently accommodated in public or community housing. These clients included people who had a mental illness and complex needs

associated with alcohol and drug use. They had also experienced family breakdown and stress related conditions (McDermott, 2008).

The aims of the HSP are to: prevent relapses into homelessness; facilitate secure tenancy; initiate appropriate referrals to community services; and to enable advocacy for secure and sustainable tenancy. This model comprised of the following components: a single point of contact from referral agent to case manager; comprehensive assessment around homelessness and tenancy risks, as well as coordination of interventions aimed at preventing homelessness and maintaining tenancy (Gillett et al., 2009).

Stable and secure tenancy is the first step for people at risk of homelessness. Once housed, a longer-term view of the necessities, challenges and goals for this population can be undertaken. When integrating specialist homelessness services, (housing, mental health support and drug and alcohol services), local conditions and circumstances need to be taken into account. (Neale, Buultjens, & Evans, 2012).

There is a paucity of research into homelessness in women. There is a lack of information concerning their tenancy, general needs and service provision. Research is particularly necessary as there is an increase in the number of women facing housing uncertainty and being at risk of homelessness (Fitzpatrick-Lewis et al., 2011; McFerran, 2010; Sharam, 2011). Moreover, for women, domestic and family violence was the main

reason for presentation to specialist homelessness services (Australian Institute of Health and Welfare (AIHW), 2014).

There are a number of integrated and referral programs and centres instituted by the local government and non-government sectors. They have been set up to help women who are at risk of homelessness and in need of support. This information includes crisis accommodation, a list of the Department of Housing, women's refuges, legal and community health centres (Homelessness NSW, 2016). Other services within New South Wales include Domestic Violence Helpline, Link2Home, (free, 24 hour service) which provides information, conducts assessment and makes referrals to homelessness services across NSW (Homelessness Australia, 2016).

One program accessible during daytime, provides drop-in maintenance support and respite centre for women in Sydney, Australia and has been part of a local community for a number of years, is one funded by a private charity. This maintenance support program provides support to women who present to the centre in crisis. Many are homeless and have a mental and/or physical illness; some have alcohol and other drug use issues, however, the majority are dealing with long-term effects of neglect and abuse. For the many women who drop-in to the centre, this is a safe, supportive, secure and welcoming environment, where they are able to restore a sense of stability and self-respect in their lives. Approximately,

70% of the clients at the centre have been identified as at risk of homelessness. The program at the centre includes case management and health care provision. The program also offers legal assistance, breakfast and lunch, assistance in finding accommodation, laundry and showering facilities, clothing stores and counselling services. They offer various group activities with volunteers assisting with 'life skills' including cooking, art and craft, personal development, creative writing and practical living skills. This program is called the Maintenance Support Program (MSP) for the purpose of this study.

The Maintenance Support Program (MSP) focuses on issues of capacity building. This helps to address inequities and can assist in building stronger communities through health promotion programs and integration of services for homeless people. These services include housing, supporting psychological and social needs, exemplify good practice policy (Minnery & Greenhalgh, 2007; Reilly, 2012). Other specialist community-based services include home and community care, alcohol and other drug treatment services, community mental health services (Department of Health and Ageing, 2013). Whilst maintaining tenancy and secure, safe housing is a priority for all people who are at risk of homelessness, follow-up and continuity of support is necessary. This maintenance of support includes advocacy for people affected by family and domestic violence, enhancing living and social skills and creating spaces for people to achieve future long-term goals and outcomes.

Currently, there is a paucity of studies into the impact or effectiveness of maintenance support programs or centres. In particular, there are a lack of studies in Australia and overseas that have examined maintenance programs from the perspectives of the clients, case managers, housing support professionals and health professionals.

1.5 Aims of the study

The objective of the study was to explore a housing support program and a maintenance support program targeting people at risk of homelessness: the aims were to:

- Identify and describe clients who used support services available for people who are at risk of homelessness.
- Explore the stakeholders' experiences and perceptions of the support provided within these programs.
- Identify issues that impeded or facilitated the management and support of the clients within these programs.

1.6 Overview and relationship of programs in the study

1.6.1 Housing Support Program (HSP)

This study was instigated to explore the HSP program from the perspective of people involved in the housing support program. This undertaking concerned not only the clients in the program but included the case

managers and housing support professionals who referred the clients to the program.

Therefore, qualitative interviews were used to explore the experiences of clients who were asked to describe their experience of being a client, how they perceived the support that they received from their case manager and the benefits of being in the program. They were also asked to suggest changes or improvements to the program, and other services that they used. The case managers were asked, in their qualitative interviews, to describe what it was like to be a case manager in the program. They were asked about their background, their relationship with referral agencies. They were questioned about the benefits of being a case manager as well as any changes they would make to the program. The housing support professionals who referred the clients to the HSP were asked in one focus group discussion to describe their perception of the HSP and working with the case managers, any difficulties they encountered, the benefits of the program, and recommendations for improving the program.

1.6.2 Maintenance Support Program (MSP)

After completing the HSP study, one recommendation arising from the findings was to investigate a support program aimed at a specific identified subgroup, that is, the subgroup at increased risk of being homeless and this subgroup was composed of women. After discussion with clinical colleagues, who worked in a support program which specifically provided

support for women who were at risk of being homeless, further research was commenced to explore the experiences of a day-time maintenance support program (MSP). This was done from the perspective of the clients, the case managers and health professionals within the MSP. This exploration was done, specifically, by the use of qualitative interviews, the clients were asked to describe their experience of being a client at the MSP, they were asked what services and activities they had used, and how the case managers have been involved. They were also asked how satisfied they were with the case managers and services and were questioned about the activities and the benefits of being at the MSP. Their advice was sought about any improvements or changes that needed to be made to the MSP. In addition to this, questions were asked concerning their standard of living, health, support, security, personal relationships and community involvement.

The case managers and health providers were interviewed about the type of work undertaken at the MSP, their relationships with the clients and referral agencies, plus any challenges, including any limitations or barriers they had faced being at the MSP, they were also questioned about any changes that they could identify, that were needed, in the MSP.

This study was concerned with reporting on the experiences and perceptions of people involved in a housing support program and a maintenance support program based on identified knowledge gaps.

Interviews and focus group data were used to describe, integrate and collate the views of participants in order to obtain a complete picture relating to both programs. The conceptual framework of Social Cognitive Theory informed the data analysis, and discussion of the findings.

1.7 Significance of the study

This study is significant in that it is the first study in Australia and internationally to report on programs which aim to support people to gain and maintain tenancy as well as maintenance of support for women at risk of homelessness from all stakeholder perspectives. In this study perceptions and experiences of those involved in the two programs aimed at supporting a vulnerable population within one state in Australia was sought. The views expressed by the respondents have given insight into both the barriers and facilitators, including the dimensions and outcomes related to their journey in the housing support programs.

A key outcome of this study is a contribution to evidence concerning the effectiveness of housing support and maintenance support programs for people who are at risk of homelessness. The social inclusion policy of recent Australian governments has been targeted towards the reduction of homelessness as a priority. Housing support options have been identified, as well as prevention, early intervention and long-term support as ways of achieving this goal. In this study, the gap in the literature concerning programs targeting people who are at risk of homelessness has been

addressed. In addition, the findings from this study, contribute to the knowledge base of viable housing support options as well as maintenance support programs necessary for policy implementation to take place.

1.8 Structure of the thesis

In Chapter One, the background of the thesis, research pertaining to the study into support programs for people at risk of homelessness is provided. The gaps in the literature have been highlighted in both housing support programs as well as maintenance support programs for a vulnerable population. The background to the study has been discussed as well as the aim and significance of the study. An outline of the relationship between the programs in the study has been given.

In Chapter Two, a detailed examination of the literature relating to this study is presented. The literature search methods, defining homelessness and the needs of the homeless are discussed. Various models of care and service provision, housing tenancies are described. A section on the needs of women and homelessness, including the various supportive programs, as well as government policies and literature, form the conclusion to this chapter.

In Chapter Three a description of the conceptual framework, Social Cognitive Theory and how it relates to the study, is provided. An overview focusing on qualitative approaches to research investigating phenomena

within complex sociocultural and dynamic environments for people who are at risk of homelessness is also presented.

In Chapter Four, the methods including the study purpose, research aims and questions are described. Ethical considerations are taken into account. This is followed by the descriptions of the data collection methods, and data analysis and the process for ensuring trustworthiness of the study.

In Chapter Five the themes and subthemes that emerged from the study findings from the perspectives of clients, case managers, and housing support professional in the Housing Support Program are reported.

In Chapter Six the themes and subthemes that emerged from study findings from the perspectives of clients, case managers and health professionals in the Maintenance Support Program are described.

In Chapter Seven the discussion of the findings is presented. A review of the key findings is presented with support from the literature. The application of the research findings to the conceptual framework, study strengths and limitations of the study are also discussed. This is followed by a conclusion and recommendations arising from the study.

1.9 Conclusion

In this chapter the study, together with the relevant research background in conjunction with present government policies in Australia is introduced. The

local response to homelessness in NSW is examined. This is followed by the aims and overview of the relationship between the programs in the study together with a description of the programs. Finally, the significance and structure of the study completed the chapter.

In the following chapter, a more in-depth review of the literature pertinent to study is completed. This consists of a discussion of the background to and a definition of homelessness, as well as exploring the needs of the homeless in relation to health, tenancy and pathways into homelessness. Women and homelessness are then described. This is followed by a discussion of models of service provision and intervention and prevention strategies. The gaps identified in the literature will give further evidence and rationale for this study.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In this Chapter a detailed examination of the literature, pertaining to this study is provided. The aims of the literature review, including the rationale for both the inclusion and exclusion criteria are presented. The search criteria are articulated. This is followed by definitions of homelessness. A description of the needs of the homeless specifically the needs of women is given. Various models of care and service provision for people who are homeless or at risk of homelessness will then be examined. A number of Government policies concerning housing tenancies and maintenance support programs for people at risk of homelessness will then be described at the conclusion of the chapter.

2.2 Aims narrative review

The narrative literature review relates to the topic and aims of the study. This involves identifying and exploring the experiences of people at risk of homelessness and as well as the housing and support initiatives that are available. A narrative review consists of a wide perspective within a specific domain of research and details the development of issues that provoke debate (Green, Johnson, & Adams, 2006; Rother, 2007). A literature review was conducted prior to the study in order to identify the gaps in the literature. This informed the study aims and objectives. Literature pertaining to homelessness and people who at risk of homelessness was investigated

and included: statistical information consisting of demographics of homelessness both nationally and internationally. Housing support programs were examined; the needs of the homeless population including health needs, and the older population were investigated. Tenancy issues, together with various pathways into homelessness, service provision, human rights and homelessness were explored. Models of care including case management and various government policies and programs were appraised. Having completed all of these tasks gaps in the literature relating to housing support programs are identified.

Literature pertinent to a specific sub-group, which is women, including their specific needs, appropriate models of care, service delivery and specific support programs are also identified. Thus, gaps in the literature concerning maintenance support programs for women who are at risk of being homeless, are identified and used to inform the final component of the study.

2.3 Inclusion and exclusion criteria

Titles and abstracts of the literature were read for relevance. Papers included were empirical studies, describing housing support and maintenance support services as well as people involved in these services. Some non-peer reviewed or grey literature was included that was relevant and was pertinent to the background and history of homelessness.

Papers that were excluded were those not specific to homelessness, experiences of housing support plus maintenance support services as well as people within these services. Other literature that was excluded was editorials, opinion pieces, commentaries, discussion papers, conference abstracts, and all non-English papers.

2.4 Search methods

This literature review discusses homelessness and was informed by a search of the academic databases that were reviewed for evidence relating to homelessness. A search was conducted of using the following databases: CINAHL, PsychINFO, CINAHL, MEDLINE, Ebscohost, Informit, OVID, ProQuest central, Cochrane Library, and Social Work Abstracts. ProQuest central and Web of Knowledge using search terms as homeless*, models of care, case management, housing support programs, support*, domestic violence, self-efficacy and social cognitive theory were explored. The search was restricted to the years from 2000 to 2016. These dates were decided upon because they included literature that described the various housing reforms that had been implemented. Other relevant literature was retrieved through searches of non-government organisations (NGOs); government publications and websites; thesis databases; Google website searches and reviewing reference lists of relevant material. Literature was reviewed to inform the discussion below, which commences with background to homelessness.

2.5 Background to homelessness

Although homelessness has been a worldwide issue for centuries, it was not considered a social problem (rather than an individual problem) until after the Second World War (1945) in Australia and the United Kingdom when there was a severe shortage of accommodation (Lloyd, 2000; Pleace & Quilgars, 2003). Prior to this, homeless people were considered as paupers and amongst the destitute (Garton, 1990). There have been romantic and popular views of the homeless man “the tramp (in English folklore), hobo (American) or swaggie (Australian)” where the homeless person chooses a mysterious and nomadic lifestyle, although this view downplays the problematic nature of homelessness (Field, 1988, p. 9). In the United States of America, vagrants, hobos and tramps were described as the homeless. However, many are transient workers who moved from state to state and a number were criminalised (Anderson, 1997). More recently, in developed countries around the world homelessness has emerged as a key social issue (Toro, 2007).

In Australia, the changing social and economic landscape of the 1970s and 1980s saw an increase in homeless numbers and people who were considered homeless comprised mostly of single men with chronic or long-term homelessness. In addition, deinstitutionalisation policies (movement of people with mental health issues into the community after the closure of large psychiatric institutions) and a decrease in low cost housing changed

the visibility, size and composition of the homeless population (Neil & Fopp, 1993). In the 1990s a deterioration of access and availability of public and other low rental accommodation was seen and in the 21st century an increase in demand for crisis and interim accommodation which was unavailable, occurred (Australian Institute of Health and Welfare (AIHW), 2008). A Commission of Inquiry into Poverty was set up in 1972 in Australia and the first report in 1975 examined different aspects and standards of living for those living in poverty, including issues related to housing and welfare services (Commission of Inquiry into Poverty, 2008). The organisations that were involved in services for the homeless, both government and non-government organisations, undertook a number of submissions and reports to express their concern about homelessness and the unaffordability and shortage of housing (Commonwealth of Australia, 2008; Council to Homeless Persons, 2005, 2008, 2015).

The population considered to be homeless now, is a continuing increasing concern in Australia (Australian Bureau of Statistics, 2012). This is borne out in 'Census of Population and Housing: Estimating homelessness' figures as the number of homeless in 2011 was approximately 105, 237, this revealed an 8% increase in numbers from the 2005 census (Australian Bureau of Statistics, 2012).

This 105, 237 figure, included the number of people 'sleeping/living rough' in parks, on the street, squatting in impoverished accommodation such as

derelict buildings and indeed this figure decreased from 7,247 in 2006 to 6,813 in 2011. Although the number of people sleeping rough has decreased, it has been found that more people are now living in overcrowded, inferior housing and can be classified as being homeless (from 31,531 in 2006 to 41,390 in 2011 (Australian Bureau of Statistics, 2012)).

2.6 Homelessness defined

There are a number of definitions of homelessness that need to be considered. The population included, but is not limited to, the aged homeless, the homeless youth, homeless families, the homeless with mental illness as well as the indigenous homeless population. The United Nations definition of homelessness includes two extensive categories: Primary homelessness (or “rooflessness”) which includes people living on the streets; and Secondary homelessness: which includes people with no usual place of tenancy and who move through various forms of accommodation frequently such as shelters and institutions (United Nations, 2009).

Similarly, the European Federation of National Organisations Working with the Homeless (FEANTSA) developed a European Typology of Homelessness and Housing Exclusion (ETHOS) to help provide a common European ‘language’ for dialogue concerning homelessness in Europe. FEANTSA oversees European not-for-profit organisations and their

homelessness definition includes: Rooflessness, house-lessness, living in insecure and inadequate accommodation (European Typology of Homelessness and Housing Exclusion, 2005). In the United States of America (U.S.), the U.S. Department of Housing and Urban Development (HUD) a person who is homeless is one that lacks a fixed, consistent and night-time dwelling, with different agencies using different definitions of homelessness affecting program eligibility (Henry et al., 2015).

In Australia, the definition of homelessness, as defined by the Supported Accommodation Assistance Program (Australia) [SAAP] 1994, included the notions of access to adequate, secure and safe housing (Department of Social Services, 2016). By comparison, a 'cultural definition' of homelessness was created by Chamberlain and MacKenzie for the 2001 Census of Population and Housing Homeless Enumeration Strategy and used by the Australian Bureau of Statistics (Chamberlain & MacKenzie, 2008; MacKenzie & Chamberlain, 2003). This definition proposed that homelessness be defined by 'community standards' for housing at the time that the reference was to be used. The 2001 Census and subsequent censuses, have tried to calculate the number people who are homeless in Australia using the following general categories: Primary homelessness, Secondary homelessness and Tertiary homelessness. Primary homelessness includes, people without conventional accommodation, as well as improvised dwellings. Secondary homelessness, includes people who move frequently from one form of temporary shelter to another; and

comprises people in specialist homeless services, emergency accommodation as well as people in transitory accommodation living with others. Tertiary homelessness includes medium to long-term boarding house inhabitants (Chamberlain & MacKenzie, 2008).

More recently, the ABS statistical definition has been informed by the core elements and meaning of home as being homelessness not just rooflessness (Australian Bureau of Statistics, 2012). These core elements include: appropriateness of the residence (for security, stability, privacy and safety) having security of tenure; being able to have access to and control of space for social relations (Australian Bureau of Statistics, 2012; Homelessness Australia, 2012; Mallett, 2004). If people do not have one or more of these elements, they can be defined as homeless. A problem with definitions is that there are homeless people who need services, but do not search for them and therefore might not be counted in the homeless population and there are those who may be considered as homeless under a definition, but do not consider themselves to be homeless. Indeed, definitions can be limiting and narrow in description.

A recent overview of current knowledge about homelessness in Australia encouraged a holistic understanding of homelessness. "When people lose their housing, not only do they lose their shelter, but they also lose a sense of safety, belonging and community connectedness central to the experience of home" (Chamberlain & MacKenzie, 2014, p. 4). Furthermore,

in order to consolidate an understanding of definitions of homelessness, a more global approach as to what individuals consider 'home' to be, should be deliberated upon and taken into account (Chamberlain & MacKenzie, 2014). Specifically, definitions of homelessness vary with individual interpretations and can be viewed from an objectivist or subjectivist perspective. Objectivists view homelessness with an emphasis on the housing structure, while subjectivists are interested in the personal meaning of living spaces, taking into account individuals' perception of homelessness (Chamberlain et al., 2014).

Therefore, defining homelessness is difficult because the reasons for people being homeless are complex and the homeless population is not a homogeneous group (Scutella, Johnson, Moschion, Tseng, & Wooden, 2012). The length of time people are in and out of homelessness varies including whether they sought assistance and the type of assistance, to change their circumstances during this homeless period (ABS, 2012). Consequently, the circumstances that homeless people often find themselves in vary and does not take into consideration the person's diverse needs after some form of shelter has been established. In the following sections, the health needs, tenancy requirements, pathways into homelessness, human rights issues and sub-groups within this vulnerable population as well as the needs of older people will be discussed.

In this current study, homelessness is defined as a situation where people do not have a secure, safe, and permanent place of abode and thus, move temporarily from one place to another provided by a government or non-government organisation until a permanent tenancy becomes available.

2.7 Needs of the homeless

2.7.1 Health needs of the homeless

Individuals who have been homeless or are experiencing homelessness tend to suffer from poorer physical and mental health and present with higher rates of morbidity and mortality than the general population (Fazel et al., 2014; Hwang & Burns, 2014). They also have less connection with education and employment opportunities and can be socially isolated (Commonwealth of Australia, 2008). According to the social dimensions of mental health, factors influencing the onset of mental health problems within a population include not only socio-economic, political and cultural factors but exposure to “proximal social stressors” (Fisher & Baum, 2010, p. 1058). These stressors include social isolation, gendered violence, low income, insecure employment, unsafe community living and insecure housing (Fisher & Baum, 2010; Shim, Koplan, Langheim, Manseau, Powers, & Compton, 2014).

In a study on homeless people in Melbourne, Australia it was found that medical conditions such as bronchitis, asthma and gastroenteritis were common, and mental illnesses such as depression and schizophrenia were

seen in almost half that population. The survey which was conducted led to the conclusion that homeless people in Melbourne had poor health and engaged in activities that put that health in jeopardy (Kermode, Crofts, Miller, Speed, & Streeton, 1998). Additionally, a study conducted in Sydney, Australia consisting of 100 respondents who answered semi-structured interviews, reported that serious illnesses were more prevalent in the homeless population than in the general population and they have more complex issues, predominantly comorbidity of mental health disorders and substance abuse disorders (Trevena, Nutbeam, & Simpson, 2001).

Similarly, Teesson, Hodder, and Buhrich (2004) using a diagnostic interview of 210 homeless men and women, found that the prevalence of any mental disorder was four times greater among the homeless population than within the general Australian population. In a more recent Australian study (case histories), researchers looked at the typical pathways into homelessness and these included: "housing crisis", "family breakdown", "substance abuse", "mental health" and "youth to adult" and questioned whether these pathways explained the reasons why some individuals remained in a homeless situation longer than other individuals (Chamberlain & Johnson, 2011, p. 60). In yet another Australian study undertaken using descriptive case study the researchers illustrated how homelessness, mental health and drug and alcohol services are integrated and thus, services needed to reflect this integration (Flatau, Conroy, Clear, & Burns, 2010).

Overseas studies have identified similar problems for the homeless. In the United States of America (USA) and in Europe, the homeless population suffer from multiple comorbidities, particularly chronic health problems including cardiovascular disease, hepatitis C, cancer, diabetes, HIV/AIDS, TB, pneumonia and obesity (Beijer & Andréasson, 2009; Hwang et al., 2011; Jones, Perera, Chow, Ho, Nguyen, & Davachi, 2009; Schanzer, Dominguez, Shrout, & Caton, 2007). Moreover, in a recent cross-sectional analysis in the US, where non-homeless people were compared with homeless people who presented to a health centre and homeless people presented with poorer health status-lifetime burden of chronic disorders including mental illness and substance abuse problems (Lebrun-Harris et al., 2013). Emergency Departments (ED) have frequent presentation of people who are homeless as well as re-presentation (Kushel, Perry, Bangsberg, Clark, & Moss, 2002; Moore, Gerdtz, & Manias, 2007). Complex and unresolved health needs for people who are homeless is highlighted in re-presentation to ED.

Indeed, in a research study involving analysis of clinical audit data in a large metropolitan hospital in Australia, the need to identify risk factors for re-presentation of homeless people to ED was highlighted since this would then facilitate early assessment and referral to community and hospital based services (Moore, Gerdtz, Hepworth, & Manias, 2010). The risk factors associated with re-presentation to ED centres comprised firstly, of

the health status of the individual including medication non-adherence, drug and alcohol issues, mental illness, infectious diseases and chronic disease. Secondly, environmental influences such as violence and social exclusion and finally, health behaviour issues concerning access to health services, community case management and emergency department (Moore et al., 2010).

The situation of homelessness is further exacerbated by the connection between mental health issues and homelessness, in that more people who are homeless tend to have a mental health issue compared to people who are not homeless (Flatau et al., 2010). In addition, co-morbidity of mental health disorders and substance use is common (Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2014; Krausz, Clarkson, Strehlau, Torchalla, Li, & Schuetz, 2013). Indeed, alcohol and other drug use is higher in this cohort than in the general population. Therefore, a priority for individuals that are homeless is access to housing and investing in health service provision. It is also necessary to explore the needs health needs of the older people.

2.7.2 Health needs of older people

Many older adults are homeless or at risk of homelessness and they have long term mental health issues; some also have substance abuse problems, needing long term support to secure accommodation (Chamberlain & MacKenzie, 2008; Jones, Howe, Tilse, Bartlett, & Stimson, 2010). An increasing number of older people are having their first time

experience of homelessness (Westmore & Mallet, 2011). In Australia, one fifth of people who are classified as homeless are over the age of 55 (Petersen & Jones, 2013). Between 2006 and 2011, the prevalence of homelessness increased by 19.2% for those aged 55 years and over compared to the overall increase of all homeless people at 17.3% (Australian Bureau of Statistics, 2012).

A comparative study, using a semi-structured questionnaire via interviews, among people over 50 years of age undertaken in Australia, the U.S and England highlighted the factors most frequently reported as contributing to their homelessness. These included physical and mental health issues, alcohol problems as well as problems with people with whom they lived. One outcome stressed in this research was the need for more targeted and specialised services particularly for the older homeless person (Rota-Bartelink & Lipmann, 2007). Furthermore, because of the increasing incidence of ageing in the population with little decrease in the incidence of homelessness, it is imperative that service providers and policy makers identify pathways in order to attend to these needs (Rota-Bartelink & Lipmann, 2014).

Older people who are marginally housed or homeless lack support services and structures and this has been underscored in a number of studies, however, their needs receive less attention than other homeless groups such as families, or homeless young people (Commonwealth of Australia,

2008; Judd, Kavanagh, Morris, & Naidoo, 2003; Petersen & Jones, 2013). Further research on services needed for older homeless or marginally housed people has been highlighted as a priority area in several studies (Chamberlain & MacKenzie, 2008; Lipmann, 2003; Ploeg, Hayward, Woodward, & Johnston, 2008). Particular research should be targeted towards the needs of older homeless women so as to be able to “shape service models and housing” for this homeless sub-group (Petersen & Parsell, 2014, p. 59).

2.7.3 Tenancy

Sustainable housing tenancies refer to policies and practices that can help people to manage their tenancy or occupancy effectively, because this enhances their lives (Seelig & Jones, 2006). When tenants are required to leave their public housing, usually involuntarily, this leads to ‘failed tenancy’, therefore homelessness is a likely outcome. This is particularly true for tenants leaving public housing, since being able to find other reasonably priced accommodation is very difficult (Habibis, Atkinson, Dunbar, Goss, Easthope, & Maginn, 2007). A ‘revolving-door syndrome’ may occur where tenants who have high need requirements might already have a debt and may be evicted because of these liabilities, thereby becoming homeless. They then become involved with the Supported Accommodation Assistance Program (SAAP) and then accumulate a larger debt when they are re-housed (Gale, 2003).

The majority of people in society (as tenants), want stability in their accommodation and this is defined as living in a long term resident accommodation (Tsemberis, Gulcur, & Nakae, 2004). Stability can be measured by the number of times people have moved out of residences over a time period or by the number of days people have continuously lived in a residence (Dickey, Latimer, Powers, Gonzalez, & Goldfinger, 1997; Hurlburt, Hough, & Wood, 1996; Rosenthal, Mallett, & Myers, 2006). A recent comprehensive review of supported and supportive housing models in the U.S. found that there was a need for clarity when defining supported housing models as inconsistency in labelling, description and measurement is limited in implementation and evaluation research (Tabol, Drebing, & Rosenheck, 2010).

Researchers have highlighted the fact that, mental health and physical problems, have an impact on the tenancy of homeless people (Taylor & Sharpe, 2008). Researchers in a USA population based sample study, collected from young adults, reported that factors linked with homelessness included socioeconomic disadvantage, dysfunctional family relationships, indicators of mental illness and drug use (Shelton, Taylor, Bonner, & van den Bree, 2009). However, other researchers suggested that mental health and drug use issues may perhaps cause homelessness or conversely might be an outcome of being homeless (Chamberlain, Johnson, & Theobald, 2007; Johnson & Chamberlain, 2008). Moreover, Chamberlain and Johnson (2011) have indicated that claiming mental illness as a

primary cause of homelessness is as inaccurate as claiming most homeless people have a mental health problem. They suggested that a solution to homelessness lies outside the medical domain particularly for those individuals that have underlying social problems including family breakdown, lack of income and affordable accommodation (Chamberlain & Johnson, 2011).

2.7.4 Pathways into homelessness

Homelessness is not a stagnant experience; it has been described as dynamic, varied and diverse with recognised pathways into, staying within and coming out of homelessness (Australian Institute of Health and Welfare (AIHW), 2014; Johnson, Gronda, & Coutts, 2008). These have included a number of factors; accumulation of debt, family separation, domestic violence and unemployment (Chamberlain & MacKenzie, 2006; Johnson & Chamberlain, 2008). In addition, individuals who have complex needs, cognitive impairment and mental disorders and are homeless or have insecure accommodation are over-represented in the prison and ex-prisoner population (Baldry, 2014).

Career pathways into homelessness have also been identified by (MacKenzie & Chamberlain, 2003) through the consequences of family breakdown, the housing crisis, and transition from youth homelessness into adult homelessness. Another term used to discuss homelessness as a trajectory is the term *iterative homelessness* meaning episodes of ongoing

and repeated homelessness, taking into account movement through various tenuous accommodation situations (Robinson, 2003).

Both human (individual agency) and structural factors can also help guide explanations of the causes of homelessness (Johnson & Jacobs, 2014). Human agency involves our ability to organise, develop and adapt to change for positive or desirable outcomes (Bandura, 2006). Structural factors include lack of affordable accommodation, poverty and employment conditions (Johnson & Jacobs, 2014). Within these constrictions, individual agency and characteristics or experiences can impact further on the vulnerability of the individual (Jones, 1997). In a recent longitudinal, qualitative study into the homelessness experienced by Australian families, the researchers explored the links between poverty and homelessness including the processes involved that exclude and disempower the individual. These processes included lack of family support, lack of institutional support, being exposed to violence, and pressure for families to surrender children to government authorities (Sharam & Hulse, 2014). Others have recognised that going into and out of homelessness can happen to anyone as homelessness is a multilayered issue with multifaceted causes, which needs complex solutions (Commonwealth of Australia, 2008).

2.7.5 Human rights and homelessness

The Human Rights and Equal Opportunity Commission in Australia [HREOC] (2016), recognised that homelessness impacts on the basic rights and freedom of the individual and acknowledged that homelessness is more than just a housing problem. From the perspective of human rights, HREOC argued that an integrated and comprehensive approach is required to address the many and varied causes, effects and outcomes of being homeless. Also, the manner in which homeless people are perceived needs to change from society seeing them as needing charity and seeking help to individuals who are entitled to promotion of their human rights together with protection (Australian Human Rights Commission, 2016).

In addition, homeless individuals may also be affected by other human rights issues apart from access to secure and safe accommodation. These issues include the right to liberty and security, a right to acceptable standards of living, the right to privacy, and the right to be free from discrimination (Australian Human Rights Commission, 2016). Discrimination is the behaviour that results from stigma, or negative stereotyping an individual. Once labelled as homeless, other terms such as outcast and fringe dweller can be added and these negative identities can stigmatise these individuals (Lawler, 2015). According to Kidd and Evans (2011), having been stigmatised with these labels an individual will often experience many negative feelings such as powerlessness and

hopelessness. When these feelings are internalised, the individual may experience loss of personal and social identity as well as a sense of social failure, leading to social exclusion.

Walsh (2006) argued that there “is a correlation between social exclusion and lack of access to fundamental human rights (p.185). Social inclusion has a multi-dimensional focus and homelessness is a component of social exclusion where the homeless become isolated and unrepresented in the community (Daiski, 2007; Minnery & Greenhalgh, 2007). People who become or are involved in social inclusion, conversely, have the opportunities, capabilities and available resources for education, employment (paid or unpaid), engagement with others and have influence over decisions concerning their own lives (Australian Social Inclusion Board, 2012). Similarly, determinants for longevity and a healthy life include school completion, transition into employment, secure housing and resource access for effective social interactions (Brown, Thurecht, & Nepal, 2012). Furthermore, people who had experienced homelessness were socially disadvantaged, had a greater possibility of disability or chronic health problems. They might also have been involved in violence more than people who were not homeless (Australian Bureau of Statistics, 2012).

A loss of social cohesion and disaffiliation from the community affects all people who are homeless (Nemiroff, Aubry, & Klodawsky, 2011). Studies in Australia have called for a ‘gendered’ analysis of homelessness to be

able to respond adequately and arguably, equitably, to the various different experiences of homelessness between men and women (McFerran, 2010).

In summary, in this section a description of the needs of the homeless population including their health needs, specific needs of older homeless people, tenancy issues, pathways into homelessness and human rights and the homeless has been given. In the next section another sub-group within this vulnerable population, that is women, will be discussed.

2.8 Women and homelessness

The impact of homelessness on women is multifaceted affecting their health and wellbeing, relationships with their families and friends and ultimately their capacity to break the homelessness cycle (Milburn & D'ercole, 1991; Robinson, 2010). Homeless women may become disconnected from their families and support networks, with some refusing contact with families (North & Smith, 1993). Homeless men tend to live on the street compared to women who prefer not to live on the street. They want more established social connections than men and are more dependent on the benevolence of others (Tsai, Kaspro, Kane, & Rosenheck, 2014). Moreover, homeless women have greater difficulties in social functioning than men, and are often socially withdrawn and not able to socialise with others. Women expressed the need for more friends and involvement in social groups. Being involved in supportive social relationships can improve coping with stresses encountered by people who

are homeless (Tucker, D'Amico, Wenzel, Golinelli, Elliott, & Williamson, 2005). In addition, women indicated that they wanted to improve or gain outside interests and have help with self-care (Herrman et al., 2004).

In Australia at the 2011 census date, the rate for females who were considered homeless rose slightly to 42 per 10,000 females while for males who were considered homeless, the rate fell slightly to 56 males per 10,000 males (Australian Bureau of Statistics, 2012). Although there are less homeless women than men, their profile of disability and inability to engage in the activities of daily life is at the same time as severe as that of men (Herrman et al., 2004).

2.8.1 Health needs of women

There are a number of physical and mental health issues that can affect women who are temporarily housed or who are considered homeless. These include various blood disorders and respiratory infections, sexually transmitted infections, dermatological problems, psychological disorders and threats of physical as well as sexual violence (Chin, Sullivan, & Wilson, 2011; Hwang et al., 2005; Wilson, 2005; Wilson, 2009)

Other studies have indicated that women becoming involved in a downward spiral because of dysfunctional families and issues of abuse, neglect, poverty and parental mental health problems and drug and alcohol issues which can lead to maladaptive patterns of living and homelessness (Tischler, Rademeyer, & Vostanis, 2007; Trickett & Chung, 2007). Other

interrelated stressors apart from physical problems such as malnutrition, unplanned or unmonitored pregnancies, sexually transmitted disease, hypertension, HIV and diabetes are mental health issues including substance use, mood disorders, low self-esteem, anxiety and psychosis (Luhmann, 2008; Trickett & Chung, 2007). Furthermore, mental health issues can impact on adaptive coping behaviour, decrease self-esteem and exacerbate social consequences of homelessness such as finding suitable accommodation and maintaining relationships (Chamberlain et al., 2014). Therefore, being able to have access to quality physical as well as mental health care is imperative (Finfgeld-Connett, 2010).

2.8.2 Impact of violence on the homeless

Homeless individuals are at a greater violence risk than those who have accommodation (Larney, Conroy, Mills, Burns, & Teesson, 2009; McQuiston, Gorroochurn, Hsu, & Caton, 2014). International researchers indicate that the prevalence of violence, particularly, sexual violence is more predominant among homeless women (Heslin, Robinson, Baker, & Gelberg, 2007; Lenon, 2000). Safety and security concerns among the homeless are therefore not surprising. Significant life stressors occurring in homeless women result in symptoms of trauma such as anxiety, depression, suicidality and substance abuse (Huey, Fthenos, & Hryniewicz, 2012; Perron, Alexander-Eitzman, Gillespie, & Pollio, 2008). In Australia, a survey of homeless men and women sampled through homeless services

concluded that homeless adults frequently experience trauma and post-traumatic stress disorder (PTSD). Although the trauma and the PTSD often preceded the homelessness, re-victimisation was commonplace (Taylor & Sharpe, 2008). Types of trauma experienced by people who are long-term homeless include physical and sexual abuse, and being a witness to individuals being badly injured, raped or killed (O'Donnell, Varker, & Phelps, 2012).

Being homeless and living rough, can cause individuals to lose hope of having improvement in their life and create emotional, physical and social vulnerabilities (Chamberlain et al., 2007). At one homeless shelter in Sydney, Australia, a cross-sectional study involving 106 people reported that all participants had experienced at least one episode of violent victimisation over the past year. One recommendation from this study was that staff needed to be aware of past victimisation and potential future victimisation together with the relationship between this victimisation and poor mental health (Chamberlain et al., 2007).

Another small (12 participants), qualitative study in Australia examined the challenges faced by individuals who were living rough experiencing extensive violence which also included living with the stigma and shame of being identified as a 'homeless person' (Robinson, 2010). One outcome of this study suggested that the homelessness service sector be required to demonstrate the use of trauma-informed approaches to services and

implement staff development and resources to work effectively with violent victimisation clients (Robinson, 2010).

2.8.3 Women and violence

One of the main catalysts for women's homelessness is domestic and family violence (Murray & Theobald, 2014). These terms are often used interchangeably or together. Domestic violence "refers to violence that has occurred between individuals who have an intimate relationship and includes physical, sexual, emotional and psychological abuse" (Council of Australian Governments, 2011, p. 2). Family violence includes violence that is enacted by a range of family and/or community members, which captures experiences of Indigenous women (Murray & Theobald, 2014). Although domestic and family violence can occur in same-sex relationships the majority of the victims are women, recognising the gendered nature of violence (Murray & Theobald, 2014). Therefore, domestic and family violence aims for coercive control through patterns of threatening behaviour, not just physical abuse (Laing & Humphreys, 2013). In the 2012 Personal Safety survey, in Australia, 41% of women had suffered some form of sexual or physical violence from the age of 15 years onwards (Australian Bureau of Statistics, 2013). Assault on women was more likely to occur from a current or former partner whereas for men who experienced violence, assault was more likely to be from a male stranger (Australian Bureau of Statistics, 2013).

Johnson et al. (2008), describe three characteristics common to a domestic and family violence pathway into homelessness. These include the experience and impact of violence, the shame attached to the experience, and women's unequal economic positioning and its relationship to homelessness. Family and domestic violence is the main reason for women and children to seek assistance from homelessness support organisations as they need to leave their home (Spinney, 2012; Tually, Faulkner, & Cutler, 2008). Moreover, women have been described as 'the hidden' homeless in this situation (Tually et al., 2008). Women who leave home have few resources or family and social support and many women then are forced to live in sub-standard accommodation such as boarding houses, cars or street sleeping (Murray, 2011). Women usually have fewer resources available to them and become more vulnerable to violence as they can end up in unsuitable accommodation (Gaetz, 2004; Nunan, 2009).

As a home should possess "a sense of security, stability, privacy, safety and the ability to control living space" women can be classified as 'homeless' who do not have the above elements in their lives (Australian Bureau of Statistics, 2012). Conversely, women and children who are experiencing domestic and family violence who continue to live "in their unsafe home with the perpetrator" are not considered to be homeless (Australian Bureau of Statistics, 2012, p. 15), although the above elements from the definition are missing in their lives. They could be considered as the 'housed-homeless' or at risk of being homeless, numbers of which are

difficult to calculate because of the above present definition of homelessness (Chamberlain & MacKenzie, 2014).

In summary, in this section there has been a discussion about the impact of homelessness on women, focusing on health needs, violence, vulnerabilities and pathways into homelessness. In the following section the various models of care and service provision for all people who are at risk of homelessness and who also have mental health issues will be discussed. This section is followed by a discussion of the service provision specifically for women.

2.9 Models of care and service provision

Case Management falls within a social model of care and is a framework that permits the client with the case manager to assess and evaluate aspects of an individuals' life, influencing their psychosocial and physical health care needs (Cooper & Roberts, 2006; Kanter, 1989). The term 'case management' was originally conceived in the United States in the 1950s and the 1960s after the closure of mental health institutions and case management was needed for these people with mental illness outside the institutions (Marshall & Lockwood, 1998; Mueser, Bond, Drake, & Resnick, 1998). Case management involves assessment, planning, facilitation and advocacy in a collaborative process designed to meet the health needs of an individual through the use of communication, maintaining contact and

accessible (Kanter, 1989; Marfleet, Barber, & Trueman, 2013; Marshall & Lockwood, 1998; You, Dunt, Doyle, & Hsueh, 2012).

Best practice in case management can change over time and continues to develop so as to provide evidence based support (Marfleet et al., 2013; Specialist Housing Support in Housing NSW, 2012). In a review examining the impact of case management, case management was seen to be effective in improving quality of life for people who are homeless, and helped reduce in-patient treatment, but appeared to be more effective when it is supportive, integrated with other services and appropriately matched to the client (Fitzpatrick-Lewis et al., 2011). In one of the few studies to evaluate perspectives of homeless people, data examined by researchers from an ethnography study concluded that mandatory engagement with case management is not as important as housing and specific support (Parsell, 2010).

In a number of overseas studies, researchers have suggested that interventions which involved housing and support, including case management and counselling, brought about a decrease in homelessness, hospitalisation and emergency visits for people with a mental illness (Clark & Rich, 2003; Goldfinger et al., 1999; Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Kumar & Klein, 2013; Sadowski, Kee, VanderWeele, & Buchanan, 2009).

For people who are homeless with mental illness, the effectiveness of housing support interventions includes programs such as 'Intensive Case Management', 'Assertive Case Management' and a range of housing models with various treatment and support components (Calsyn, Klinkenberg, Morse, & Lemming, 2006; Coldwell & Bender, 2007; Dieterich, Irving, Park, & Marshall, 2010; Hopper & Barrow, 2003; Hwang et al., 2005; Lehman, Dixon, Kernan, DeForge, & Postrado, 1997; Nelson, Aubry, & Lafrance, 2007).

'Critical Time Intervention' (CTI), is another model which is described as both a primary intervention, that is, trying to prevent people who are housed becoming homeless and a secondary intervention, that is limiting the duration and the effects of homelessness, for people in transition from transient accommodation to permanent accommodation (Chen & Ogden, 2012; Herman, Conover, Felix, Nakagawa, & Mills, 2007; Herman, Conover, Gorroochurn, Hinterland, Hoepner, & Susser, 2011; Tomita & Herman, 2012). 'Assertive community treatment' (ACT) or "continuous treatment team" is treatment shared by multidisciplinary team members, where case managers establish and maintain therapeutic relationships and intensive connection with the consumer, having weekly contact in their community, and delivering comprehensive services when consumers are in a crisis (Lerbæk, Aagaard, Andersen, & Buus, 2015; Rosenheck, Kaspro, Frisman, & Liu-Mares, 2003; Salyers, McGuire, Rollins, Bond, Mueser, & Macy, 2010). It is designed for consumers with severe mental illness who

have been repeatedly hospitalised and not been able to engage in traditional case management (Salyers et al., 2010). The main premise of ACT is to treat clients or consumers within the community and promote recovery based principles of empowerment and self-determination, although embracing these principles may not always be practised (Salyers & Tsemberis, 2007).

Intensive case management (ICM) is also community based care with the aim of providing long term care for people with mental illnesses (Dieterich et al., 2010). ICM occurs when instead of a team approach, a case manager is available to the consumer over the 24-hour period and there is a smaller caseload than ordinarily (Hurlburt et al., 1996; Nelson et al., 2007). The case manager's role in ACTs as well as in ICMs programs has been seen as both that of a therapist and a friend (Calsyn et al., 2006).

In addition, intensive case management and assertive community treatment for people with substance use problems and who are homeless has been seen as successful in a numbers of areas including improved client satisfaction with the service and improved quality of life (Chen, 2008; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). Other assertive outreach initiatives such as the Common Ground model of supportive housing target the chronic homeless population (Haggerty, 2008). The long-term homeless (sometimes referred to as chronic homeless) are seen as having more complex needs than other homeless people, including

disabilities, mental health issues and substance abuse (Commonwealth of Australia, 2008). The Mercy Foundation in conjunction with other compatible organisations in Australia formed the Australian Common Ground Alliance (ACGA) which helps develop permanent supportive accommodation throughout Australia particularly for the long-term homeless (Mercy Foundation, n.d).

For people who have a mental illness, case management by itself has been seen as not as effective in reducing homelessness as having housing with case management (Chinman, Rosenheck, & Lam, 2000; Milaney, 2011; Nelson et al., 2007). Moreover, the need for a focus on housing as a fundamental determinant of mental health has been highlighted (Battams & Baum, 2010). Nevertheless, in a report examining the effectiveness of case management for people experiencing homelessness, Gronda (2009) stated:

.... the evidence shows that, for any given client, case management practice which provides a persistent, reliable, intimate and respectful relationship, supported by access to resources, will deliver the best possible outcomes (p.137).

Furthermore, in a study by Flatau and Zaretsky (2013) they reported that case management approaches for service provision are integral components of integrated services (that is homelessness services, mental health and drug and alcohol services). These approaches are particularly aimed at clients with complex needs.

Recently, an economic cost benefit analysis of a 'Homeless to Home' healthcare after-hours service in Brisbane, Australia showed that the benefits of the service outweigh the costs (Connelly, 2013). The Homeless to Home reduced both inpatient admissions and ED presentations, including health-related quality –of-life gains and net social benefits. This is a nurse-led health service, working in collaboration with outreach team of housing focused community workers providing direct care to homeless people on the street and then when housed. Integration of housing with this healthcare service is a critical component (Connelly, 2013). This leads to a discussion about the housing first model.

2.9.1 Housing first model

A recent service provision and pathway to housing model has been introduced in Australia - the Housing First model. This originated in the USA in the 1990s and targeted people who were chronically homeless (broadly including the homeless with other issues such as being physically & mentally unwell, drug & alcohol issues, long term unemployment) to address these problems before being offered an opportunity to have their own independent housing (Johnsen & Teixeira, 2010; O'Connell, Kaspro, & Rosenheck, 2009; Pearson, Montgomery, & Locke, 2009; Pleace, 2011). The Housing First model includes placement of a person in a stable housing situation, with available support services incorporating assertive outreach for people with mental illness and harm reduction measures for

people with substance use issues and case management in various forms such as individual or team case management (Pearson, Locke, Montgomery, & Buron, 2007).

A number of central expectations underpin the Housing First model including: access to permanent housing rapidly; the consumer having a choice; there is separation between housing and services; an ongoing recovery process is implemented and community integration is involved (Tsemberis, 2010). Whether a Housing approach is transferrable to an Australian context is still in the process of being researched but it has re-affirmed how important housing is for recovery of an individual who is homeless or at risk of homelessness (Johnson, Parkinson, & Parsell, 2012; Tsemberis & Eisenberg, 2000). It is important to focus on services that are specific to the needs of women.

2.9.2 Specific services for women

As the homeless population is not a homogenous group in terms of service provision and delivery, various support services are required for their diverse needs. Although appropriate accommodation or housing is important, other factors as previously mentioned associated with homelessness, require a range of services to be taken into consideration (Coles et al., 2012; Fingeld-Connett, 2010; Limbrick, 2006). Services for the homeless have largely focused on shelters for homeless men, refuges for women and children because of domestic violence and youth refuges

(McFerran, 2010). Women who are homeless are considered to be amongst the most socially and economically disadvantaged groups in Australia because of their greater contact with violence, poverty and social and economic inequity (Homelessness Australia, 2013; McFerran, 2010).

Furthermore, women who are homeless have high rates of psychiatric morbidity (Chambers et al., 2014). Disparities in health for women who are homeless exist when compared to the general population, women have higher rates of mental illness, substance abuse, victimisation and higher rates of mortality (Arangua, Andersen, & Gelberg, 2005; Schanzer et al., 2007). Therefore, early integration of health with social interventions, support women with mental health issues to achieve well-being (Montgomery, Brown, & Forchuk, 2011). Within these interventions, specific interventions addressing women's experiences of poverty and homelessness, focusing on issues of stress, powerlessness, social isolation and exclusion need to be considered (Goodman, Smyth, & Banyard, 2010).

As mental health issues can emerge from the long-term impacts of domestic and family violence, there is a need for trauma-informed approaches to care while maintaining social responsibility and advocacy which supports best practice (Cleary & Hungerford, 2015; Laing & Humphreys, 2013). Furthermore, as people are recognising trauma as both being a cause as well as a component of being homeless, there is an

urgent need to have community places of care and support (Robinson, 2011). For women who are experiencing trauma, particularly from family and domestic violence, there is a need for promotion of “healing and social reconnection” combined with housing and therapeutic support (Robinson, 2011, p. 142).

A combination of preventative measures in an integrative approach combining legal, housing and welfare policy and practices has been shown to improve safety for women and children who have experienced domestic and family violence (Spinney, 2012). Housing measures within Australia include housing agencies having emergency support, 24-hour response teams; welfare measures include outreach services and refuge schemes; Staying Home Leaving Violence (SHLV) schemes and personal development and confidence-building assistance (Spinney, 2012). In addition, ‘rapid-rehousing’ programs, aimed at women and children in family or domestic violence situations, have enabled instant re-housing of people at risk of being, or who are experiencing homelessness (Holst, 2013).

Early prevention measures to develop skills such as adaptive problem solving, decision making and interpersonal skills have been identified from a qualitative meta-synthesis study on resolving homelessness among women from nurses working in the homeless healthcare area in the USA

(Fingeld-Connett, 2010). These skills reflect the need for a strengths based approach seen in the development of Trauma Informed Care (TIC).

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

(Hopper, Bassuk, & Olivet, 2009, p. 133)

Furthermore, in a literature review recently undertaken on trauma and homelessness concluded that there was the need to establish a trauma-informed practice framework for service providers (Hopper et al., 2009; O'Donnell et al., 2012). Such a framework could assist service providers to constructively work with individuals who are experiencing homelessness given the relationship established between events that are traumatic and homelessness (Hopper et al., 2009; O'Donnell et al., 2012).

In summary, in this section the various models of care and service provision including case management, assertive community teams, Housing First model and concluding with service provision specifically for women has been discussed. In the following section government responses, both national and NSW based, with specific programs and policies including early prevention and intervention will be illustrated.

2.10 Government responses – policies and programs

A number of programs instituted by government bodies in Australia to support people who are at risk of homelessness and who need housing have been implemented. The Supported Accommodation Assistance Program (SAAP) was created in 1985 to establish Commonwealth nationally coordinated homelessness programs instead of individual responsibility and funding by state and territory governments. The policy was driven by the Australian Government with everyday management of the Program being a state and territory government responsibility (Australian Institute of Health and Welfare (AIHW), 2008).

The National Homelessness Strategy was instigated to address the increasing numbers of people who were homeless or at risk of being homeless in Australia. This Strategy was seen as a united national response to homelessness as state policies, programs and interventions were organised (Minnery & Greenhalgh, 2007). Recently, specialist homelessness agencies funded under the Council of Australian Governments (COAG) undertaking the National Affordable Housing Agreement (SCRGSP (Steering Committee for the Review of Government Service Provision), 2012) and the National Partnership Agreement on Homelessness (Australian National Audit Office, 2013) provide a local response to homelessness by means of a variety of services in each State and territories. In NSW, under the Department of Family and Community

Services (FACS) specialist homelessness services (SHS) have superseded SAAP in order to support people who are at risk of homelessness with services including crisis accommodation and links to other support services (Family and Community Services (FACS), 2014).

One of the issues recently highlighted concerns the lack of limited housing and stability for many people with mental illness (Mental Health Council of Australia, 2009). In response to this need, in NSW the Housing and Accommodation Support Initiative (HASI) was established and expanded to help support people with a mental health diagnosis gain access to accommodation support and mental health services, whilst maintaining tenancy and assisting people in mental health recovery (Bruce, McDermott, Ramia, Bullen, & Fisher, 2012). In other states and territories within Australia similar programs delivering integrated mental health services also exist (Flatau et al., 2010). An evaluation by HASI established that links housing with suitable clinical support and rehabilitation within service provision can improve the lives of people who live with disabilities associated with mental illness, by making them more independent (Bruce et al., 2012).

There have been many programs implemented at a National and local level to address the rising number of homeless. However, very few of these programs have been appraised, particularly from clients, case managers and service usage patterns, perspective (Costello et al., 2013; Flatau et al.,

2006). The consultative 'A New Approach to Homelessness - Which Way Home', 2008 [Green Paper] (Mental Health Coordinating Council, 2008) paper nominated innovative service models and evaluating best practice models as part of the research agenda on national homelessness. Furthermore, the 'National Approach to Homelessness - The Road Home', 2008 [White Paper] document (Commonwealth of Australia, 2008) contains a description of ways of creating stable accommodation and support options to 'break the cycle' of homelessness (Australian Institute of Health and Welfare (AIHW), 2008, p.15).

There is little information available on the effectiveness of models or programs at a local government level, although both the Green Paper and White Paper emphasised the need for evaluation of innovative service models and programs for the homeless. In addition, The National Affordable Housing Agreement (NAHA) that commenced in 2009 is now the framework for a nationwide approach to lessening homelessness. This framework calls for further integration of specialist and mainstream services to ensure a better connected service system (Flatau et al., 2010). The main areas that were targeted in the White Paper to prevent homelessness are early intervention of services; ensuring services are more connected, integrated and responsive; and ensuring people who are homeless can be assessed and moved promptly through the crisis system into stable supportive accommodation to avert reoccurrence of being homeless. In a recent literature review in which researchers examined interventions for

working with homeless or at risk of homelessness young people re-iterated that integrated service provision will provide more effective interventions (Barker, 2012). Therefore, good practice policy for the homeless person incorporates housing, psychological and social long-term support, integrated with health promotion program that capacity build (Minnery & Greenhalgh, 2007; Tsai, Mares, & Rosenheck, 2012).

Homeless people often have higher levels of poor mental health leading to an increase in long-term disability for many facets of life (Chambers et al., 2014; Gadermann, Hubley, Russell, & Palepu, 2014). A recent report undertaken by a research synthesis approach for the New South Wales Premier's Council on Homelessness identified that service integration and care coordination is in need of improvement within the mental health area (Costello et al., 2013). In addition, good practice programs are aimed at facilitating independence by focusing on clients acquiring skills leading to "social competence, securing a 'home', maintaining financial stability, and exiting social exclusion" (Minnery & Greenhalgh, 2007, p. 645).

Specialist Housing Services (SHS) were increased after the White Paper reforms and funding on specific activities was given, although overall funding to relieve pressure on SHS, caused by increased demand and lack and static funding was not considered (Homelessness Australia, 2012). As previously mentioned, data from the 2011 Australian census, showed between 2006 and 2011 an increase in homelessness figures of 17.3 per

cent from 89 728 to 105, 237 people, particularly for people living in temporary accommodation and severely crowded conditions (Australian Bureau of Statistics, 2012). This surge of homeless numbers increased the role of SHS and suggested that there was not sufficient importance originally given to these services in the White Paper reforms (Homelessness Australia, 2012). In a recent report from the Australian Institute of Health and Welfare (AIHW), it was shown that clients with current mental health issues needing assistance through the SHS had increased during 2014-2015. During this period, the homeless clients who accessed the SHS, over 51% reported having a current mental health issue (Australian Institute of Health and Welfare (AIHW), 2015). Domestic and family violence was the most common reason for seeking assistance from homelessness services (Specialist Homelessness Services (SHS), 2015).

Various reforms, including the White Paper, directed at people who were homeless or at risk of being homeless did reduce some housing instability among those targeted, but prevention of homelessness in the population has not reduced overall as structural issues such as affordable housing supply has not been targeted or addressed (Parsell & Marston, 2012).

In 2009, the National Partnership Agreement on Homelessness (NPAH) commenced a joint funding agreement between the Commonwealth, states and territories in Australia to support “people who are homeless or at risk of homelessness achieve sustainable housing and social inclusion”

(Homelessness Australia, 2016). Within this agreement, the states and territories had the right to determine the contract for individual services, where they are located and amount the service receives. Partnerships include not-for-profit, community and business groups (Department of Social Services, 2016). Whilst funding has been on a yearly basis since 2009, impacting on forward planning and efficient operation of services, there is now a two-year plan 2015-2017 in progress after a successful campaign driven by Homelessness Australia (2016). The NPAH funding for 2015-2017 has a focus and priority on women and children who are experiencing family and domestic violence and also on youth who are homeless (Department of Social Services, 2016). Reforms to affordable housing and homelessness and future decisions concerning housing assistance and homelessness services will be made at the end of 2016 when a report will be completed in 2017 and then discussed by the Council of Australian Governments (COAG) (Department of Social Services, 2016).

2.11 Intervention and prevention

The earlier intervention occurs, the more positive the psychosocial and health outcomes for people at risk of homelessness. Intervention and prevention strategies have included viewing homelessness as a process instead of identifying different types of people as homeless. Other views, as mentioned previously, focus on pathways in and out of homelessness instead of a one off event (Clapham, 2003). A further view suggests a

framework of the homeless as a career trajectory consisting of “youth career”, the “housing crisis career” and the “family breakdown career”. This view illustrates various interventions that can be implemented during the phases of “the homeless career, such as prevention, early intervention and long term support” (Chamberlain & MacKenzie, 2006, p. 199). A failure in providing family support has been reported as the significant factor contributing to the youth homelessness trajectory (Australian Institute of Health and Welfare (AIHW), 2008).

Health promotion and disease prevention is part of early intervention and primary health care. Health professionals need to be aware of the barriers to accessing early intervention programs together with the health status of the individual, their needs, beliefs, values and the preferences that face this vulnerable population (Zabaleta-del-Olmo et al., 2015). Moreover, a recent narrative synthesis of current literature on primary health care needs of homeless youth found that improvement in housing together with street based clinic services, therapy and case management positively impacted on mental health and substance use outcomes (Dawson & Jackson, 2013).

Early intervention also involves addressing risk factors such as poverty, unemployment, mental health and drug use problems and then constructing protective factors such as healthy family relationships and community connections (Sanson, Nicholson, Ungerer, Zubrick, & Wilson, 2002; Sanson, Nicholson, Ungerer, Zubrick, Wilson, et al., 2002).

Promotion of health and wellbeing in families and communities can reduce many of the harms associated with homelessness (Sanders, Cann, & Markie-Dadds, 2003). In addition, the time spend being homeless can increase a young person's vulnerability to multiple negative outcomes, underlying the importance of early intervention (Johnson & Chamberlain, 2008; Mayock, Corr, & O'Sullivan, 2011).

In order to facilitate the process out of homelessness, maintaining a connection with family members and capable support services has been recognised as successful (Mallett, Rosenthal, Keys, & Averill, 2009; Milburn et al., 2009). Furthermore, newly homeless young people who have contact with parents, particularly mothers, increases the probability of them returning home and over time, remaining home (Milburn et al., 2009).

Recently, the NSW Family and Community Services (FACS) conducted a consultation with government and non-government stakeholders to inform the Homeless Youth Assistance Program [HYAP] service delivery framework (Homeless Youth Assistance Program (HYAP), 2016). This is an organisation focusing on the immediate safety and wellbeing of children who are homeless or at risk of homelessness. The need to have engagement with external partners in early intervention was the significant theme during the consultation process. Prevention strategies, included improved case management, increased child protection responses, identification and intervention in schools; and improved discharge planning

when dealing with mental health facilities, emergency departments, and Juvenile Justice were identified. In addition, the need for sustained therapeutic, trauma-informed interventions was considered essential when working with young people (Tomlinson & Klendo, 2012).

The three key strategies which form part of the NPAH to support a reduction in homelessness are early intervention and prevention; breaking the homelessness cycle and expanding and improvement of services (Homelessness Australia, 2016). The NAHA and the Australian Homelessness Taskforce in 2008 acknowledged the need to provide opportunities for people who are homeless or at risk of homelessness to have improved access to stable, sustainable housing, supported by quality services, as well as employment and training opportunities. Equally important is the ability to achieve community participation and social inclusion with the goal of involvement leading to the prospect of leaving a homeless lifestyle (Grace, Malone, & Murphy, 2016).

Projects that have been instigated over the past five years under the NSW Homelessness Action Plan (HAP) 2009 – 2013 (Institute, 2013) have shown a shift in homelessness research from crisis responses to prevention and early intervention to diminish risks related to people becoming homeless. Projects included support for people at risk of eviction; people existing institutions; youth outreach support; long-term housing and accommodation support for people with complex needs and support

services for women escaping domestic violence. Final reports on these evaluation strategies are still being completed. Preliminary reporting suggests success factors in the projects include case management focused on client outcomes with long-term relationships and appropriate accommodation being established prior to existing institutions. It also includes intensive caseworker support increasing a sense of confidence of clients to navigate services and systems. There is also a need to focus on support for sustaining tenancies through advocacy, developing knowledge and skills and overall capacity building for the clients (McDowell, 2013; Parsell, Petersen, & Culhane, 2016).

In summary, in this section government responses to homelessness with various policies and programs have been described. In addition, National, State and local programs were discussed. In this literature review, the researcher has highlighted that there is a lack of research in this area. A discussion on early intervention and prevention concluded this section. In the following section programs needed by women who are homeless or at risk of homelessness including health services, life management programs, improving quality of life and social support programs will be debated.

2.12 Maintenance support – women

As mentioned previously, health and health disparities for homeless women in contrast to the general population, women have higher rates of a mental illness, substance abuse, victimisation and higher rates of mortality

(Arangua et al., 2005; Schanzer et al., 2007). Moreover, older, single women experiencing homelessness and housing insecurity were a group in urgent need of services now and in the future (Gilbert, 2010; McFerran, 2010; Sharam, 2010). There is a paucity of Australian data on the day-to-day existence or long term needs of this group. Furthermore, there is also scant information about day programs, maintenance programs and support centres that cater specifically for women.

A number of authors have described the lack of, or access to quality health services for women (Gelberg, Browner, Lejano, & Arangua, 2004; Luhrmann, 2008; Teruya et al., 2010; Trickett & Chung, 2007). Services that are of primary importance after housing and physical / mental health care services included health promotion programs, comprehensive assessments, drug and alcohol rehabilitation and treatment for chronic conditions (Tischler et al., 2007). So as to address improvement in mental health needs within this population, programs that focus on victimisation, substance abuse and lack of social support need to be implemented (Chamberlain et al., 2014). Similarly, a recent cross-sectional mixed method study reported continuing, on-going, long-term support was an important component of integrated services within women and children's homeless support centres. However, this area was not addressed and was underfunded (Flatau & Zaretzky, 2013).

One USA study that examined homeless women's experience (n=15) of social support from service providers was a phenomenological study undertaken in a women's homeless shelter (Biederman, Nichols, & Lindsey, 2013). The voices of the homeless women indicated that social support, that is, 'being cared for' was equally as important as professional support within encounters with service providers (Biederman et al., 2013).

Additionally, in another program, a life management enhancement group program, which was undertaken for an older minority women's group in the USA to overcome homelessness (Washington, Moxley, & Taylor, 2009). This research illustrated the importance of developing personal control and self-confidence in social relationships which could improve and maintain appropriate coping mechanisms to overcome their homeless situation (Washington et al., 2009). Organisations that promote positive relations between the service user and the service provider can potentially improve the social or economic capital of the service user, developing trusting relationships (Barker & Thomson, 2015).

An intervention to advance well-being and quality of life among vulnerable populations would be to combine multiple resources (including health provision, housing advocacy, mutual support groups) with self-efficacy practice. Self-efficacy is an individual's belief in a course of action to achieve a desired outcome (Bandura, Baum, & Newman, 2007). This combination of practice would involve supporting environments to sustain,

improve and promote health particularly for people suffering adversity such as people who are homeless or at risk of homelessness (Washington & Moxley, 2013). Furthermore, socially-supportive relationships can improve personal control, coping resources, a sense of well-being and reducing stress (Bandura et al., 2007; Biederman et al., 2013). Further discussion concerning self-efficacy is articulated in Chapter 3, as part of the Social Cognitive Theory framework for this study.

Literature reviewed on understanding homelessness emphasises the need to look at homelessness as “multidimensional and storied” thereby investigating the whole life story of the individual, not “just selected episodes of rooflessness” including the role of key service providers and how these roles relate to homeless service provision (Somerville, 2013, p. 409). Service providers within the homeless support sector include health professionals, housing, welfare professionals and case managers working within various organisations such as day centres, homeless shelters and refuges. To achieve successful outcomes for the journey from homelessness to sustainable, successful housing, on-going support with the involvement of interested and concerned people within a team approach is necessary.

2.13 Summary

In this chapter literature that sets the scene for this study, that is, the experiences of people involved in housing support and maintenance

support programs for people at risk of homelessness is discussed. Information presented has focused on defining homelessness, discussing models of care and service provision, housing tenancies, the needs of people at risk of homelessness and pathways within homelessness. A section on the needs of women and homelessness, various supportive programs as well as government policies has also been described.

In the following chapter the methodology undertaken, that informed the research design and rationale for undertaking this design is described. An overview of qualitative, paradigms is given, together with an overview of Social Cognitive Theory as the theoretical framework guided the study.

CHAPTER 3: METHODOLOGY

3.1 Introduction

Research methodologies guide and frame the research that is undertaken. An action plan and justification of the choice of methods undertaken to collect and analyse the data is also provided (Creswell, 2013; Grove, Gray, & Burns, 2014). In this chapter, Social Cognitive Theory is introduced and used to inform the research method. Use of Social Cognitive Theory enables greater understanding of the perceptions and experiences of people involved in a housing support program and a maintenance support program. An overview of the research paradigms that inform the design of the studies and rationale for the design is then given. The basis and features of the qualitative research paradigm, that is, the qualitative descriptive methodology is discussed.

3.2 Theoretical framework

A theoretical framework can be seen as a network of connected concepts or ideas within a framework which provides an understanding of a phenomenon (Jabareen, 2009). Within research, this framework can assist researchers make meaning of data and communicate findings (Maxwell, 2013; Smyth, 2004).

Theoretical and conceptual frameworks, which involve vulnerable populations, have come from similar health disciplines such as nursing, medicine, sociology and public health. These frameworks have included

social cognitive theory, the theory of reasoned action and the health belief model (Nyamathi, Koniak-Griffin, & Ann Greengold, 2007). Other frameworks or models such as the Vulnerable Populations' Conceptual Model have focused on health but does not include other factors (Aday, 1994; Flaskerud & Winslow, 1998). The vulnerable populations' conceptual model concentrates on resource limitation and examines the risks to the vulnerable population on health outcomes, rather than exploring societal factors that may influence health.

Another model is the Comprehensive Health Seeking and Coping Paradigm (Nyamathi, 1989) which has as its integral focus, nursing goals and interventions. In this current study, the focus is on health outcomes and the impact of societal factors on the health of a vulnerable population. The perspectives of multiple stakeholders concerning support programs for people at risk of homelessness, are also explored. These stakeholders include clients of housing and maintenance support programs, case managers, housing support professionals who refer clients to programs and other health professionals.

The Social Cognitive Theory framework, chosen as a framework for this study focuses on, personal, environmental and behavioural factors that influence an individuals' choice of pathway in life, (it is not limited to health choices). Therefore, it is the most appropriate framework to adopt in order to answer the questions posed for this vulnerable population under study.

3.2.1 Social Cognitive Theory (SCT)

SCT explores the dynamic and constant interaction between the individual, their behaviour and their environment. By using this theory one is able to identify the relationship between psychosocial, biophysical and environmental factors that influence behaviour and this enables one to gain an understanding about why people behave in certain ways in certain situations. This subsequently has an effect on an individual's self-efficacy, which is their perceived ability to cope with and manage specific situations, and will determine what they are able to achieve (Bandura, 1997). For people who are at risk of homelessness, their ability to achieve independence depends on their environment, their personal coping abilities and their physical self. Since there is a paucity of research into this experience, it was decided to explore this phenomenon using a qualitative descriptive approach, with minimal theoretical conceptual constraints and interpretation. Since this approach is suitable in attaining direct answers to this research question: 'What are the experiences of people involved in a housing support program and a maintenance support program for people at risk of homelessness'.

In western societies, people in general have the capacity to influence the way they live their lives. How people actually live their lives and behave in particular situations is determined by a number of interrelated factors such as education, personal values, cultural mores, religious beliefs and

economic factors. As a way of developing awareness of these factors, the development and concepts of SCT will be briefly outlined.

3.2.2 Development of SCT

Since the 1950s there have been many proposed social learning theories (Patterson, 1982; Rotter, 1960) to explain behavioural patterns and how people learn. In particular Bandura, broadened some of these theories to include emotions and other aspects of behaviour as a means of understanding behaviour and how behaviour can change over time (Bandura, 1984, 1986; 1989; Bandura et al., 2007). This broadened and eventuated in relabelling social learning theory as social cognitive theory, in which emphasis is placed on the cognitive capacities and information processing capacities of the individual in mediating social behaviour rather than the psychoanalytic and stimulus response found in learning theory (Grusec, 1992; Rosenstock, Strecher, & Becker, 1988).

Therefore, Bandura's SCT provides an explanation of how the interplay between personal, environmental and behavioural factors influence how individuals learn, acquire and maintain certain behaviours. This interaction is known as reciprocal determinism. Interactions between the individual's personal or cognitive factors, the physical and social environment in which the behaviour is performed, and then, in turn, the environment is influenced by the behaviour of the individual (Bandura, 1977, 1986, 2004). These reciprocal relationships drive social learning and behaviour.

In this study, the *cognitive or personal factors* include factors occurring internally within the individual, that is, within mental processing including emotional responses, self-efficacy, expectations, beliefs, attitudes, as well as the individual's interpretation of the information.

The *physical and social environmental factor* are factors external to the physical person that can impact on their behaviour. The physical environmental factors include the individual's housing situation, the weather, and shelter during the day. Social environmental factors comprise of family, friends, interactions within support programs with case managers, health and housing professionals and volunteers.

The *behavioural factors* focus on the reactions of the individual to various responses from their physical and social environments and whether that behaviour is goal directed with plans of action to guide motivation. Perceived enablers in conjunction with social and structural constraints can enable change in the individual to occur (Bandura, 2004). The below figure (Figure 3.2) displays this reciprocal interaction between factors in this study.

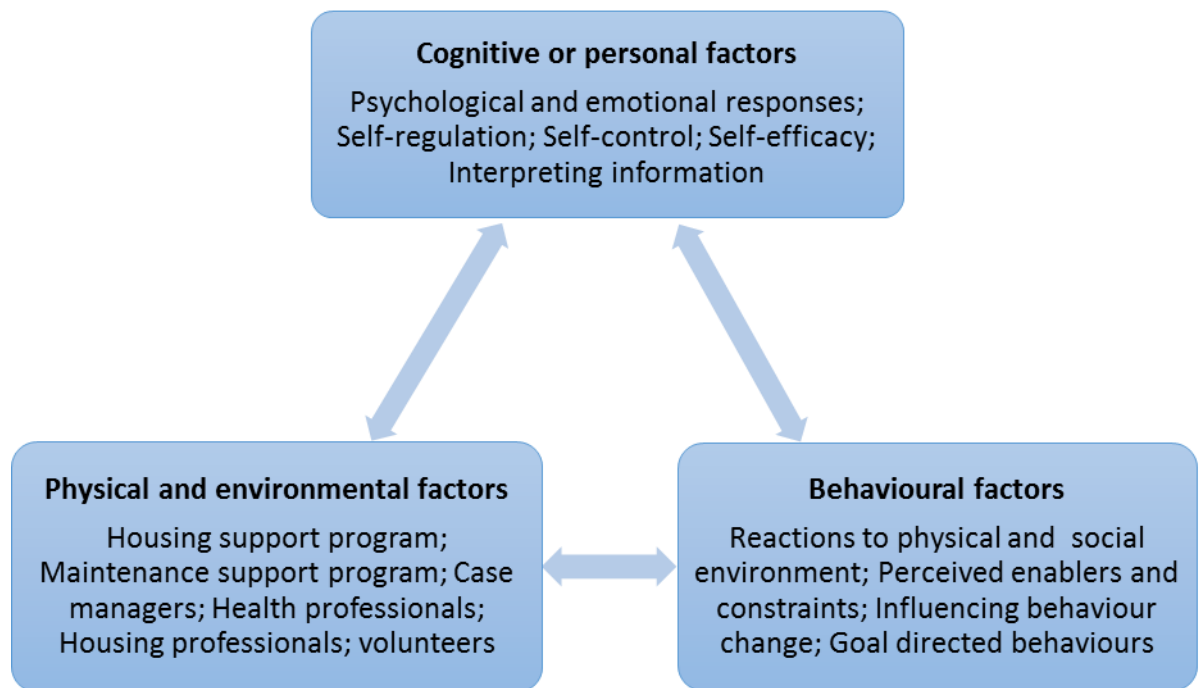


Figure 3.2: Interaction between cognitive or personal, environmental and behavioural factors (that is, reciprocal determinism).

Central tenets of the SCT including a further description of reciprocal determinism together with self regulation and self-efficacy are explored in the following section.

3.2.3 Central tenets of SCT

Reciprocal determinism or the concept of reciprocity or triadic reciprocity was developed to explain the complex interaction between personal, behavioural and environmental factors (Bandura, 1984, 1986, 2001;

Bandura et al., 2007). The main premise of this concept is that behaviour is not only an outcome of a person in a given environment or situation but behaviour itself influences the person and the environment. As stated by Bandura (1984) "... the self-system is embedded in a network of reciprocal causation" (p. 508).

Within this model of triadic reciprocity, personal, environmental and behavioural factors all connect and influence each other. In turn reciprocity reinforces social behaviour (Bandura, 1986). An individual's thoughts and actions are seen as a consequence of reciprocal relations between the individual's personal factors (intelligence, affective and psychological factors) and how this affects the social environment or situation and the behaviour they exhibit in that situation. When individuals act on events or situations in which they find themselves, they are influenced by constraints and opportunities in the environment including the physical environment, culture and social network systems. Feedback that the individual receives from their actions or behaviour together with conscious self-regulated behaviour and interpretations the individual makes of their own behaviour influences future choice within the environment (Bandura, 1977, 1986; Pajares, 2002). In addition, a person's skill and knowledge level, self-efficacy, and the anticipated outcome and perceived control over performing behaviour also influences a person's behaviour (Bandura, 1977, 1984, 1986).

Bandura (2001) postulated that self-efficacy beliefs “are the foundation of human agency” (p.10). Moreover, Bandura refined SCT by emphasising the role that this personal or human agency undertakes in learning, and stated, “the capacity to exercise control over the nature and quality of one’s life is the essence of humanness” (2001, p.1). People are considered both as producers and as products of their environment and social systems. Instead of merely undertaking an experience or being passive, people are considered “agents of experience” (Bandura, 2001, p. 4). In order to give people fulfilment, meaning and direction in their daily experiences, goals and tasks need to be accomplished. This is achieved by individuals using their intellect, sensory and motor systems by being self-organised, proactive, self-regulating and self-reflective (Bandura, 2001, 2006).

Within SCT, there exists the individual psychological constructs of self-regulation and self-efficacy (Bandura, 1989). *Self-regulation* involves the effort the human self uses to alter an individual’s inner state (Bandura, 1989). By altering the inner state, an individual can exercise some control in a given situation. The result of self-regulation is that the self is brought into accepted (therefore regular) standards of behaviour, essential for effective functioning in the world at large (Baumeister & Vohs, 2004; Zimmerman, 1998). This self-regulatory system also enables individuals to influence, control and evaluate their own behaviour. The outcome of the evaluation process results in individuals interacting with the environment

and attempting to influence or alter their environment depending on their level of control (Bandura, 1984; Bandura et al., 2007; Pajares, 2002).

Self-efficacy or personal efficacy can be defined as a person's perceived capability in achieving a goal (Bandura, 2004; Epel, Bandura, & Zimbardo, 1999). Furthermore, self-efficacy involves how a person uses their inner, accessible resources and strengths to achieve goals and overcome obstacles. When a person believes in their own self-efficacy, they are able to accomplish a task. Self-belief plays a major role in goal attainment which is often task or situation specific (Pajares, 1997). The activities that people choose, the amount of effort they will exert and the length of time that they will exert this effort in abnormal or stressful situations is often determined by self- efficacy expectations (Bandura et al., 2007).

Central to the theory of self-efficacy is the notion of freedom of choice and that people have some influence over what they do in life. When self-efficacy is combined with self-influence a particular behaviour pattern will be developed for the individual (Bandura, 1995; Peterson & Bredow, 2009). The theory of self-efficacy has proven to be a valuable guide in order to understand behaviour and how that behaviour change can be facilitated (Resnick, Galik, Gruber-Baldini, & Zimmerman, 2009).

Self-efficacy is required by an individual in order to undertake an activity or join in a social group. Identifying, challenging and altering low self-efficacy is essential to successful and adaptive functioning (Usher & Pajares, 2009).

Bandura et al. (2007), proposed four sources of interpreting information that can assist in the development of self-efficacy in an individual, these are: a person's own mastery experience; verbal persuasion; vicarious experience and physiological states.

Mastery experience refers to the point at which an individual understands the task sufficiently to perform that task after a number of repeated attempts. During the mastery experience, individuals can interpret the results of their actions and use these results to develop a capacity to engage in future actions/tasks. Confidence is then developed and little input or further direction is needed from others. When tasks are mastered successfully self-efficacy expectations are raised, however, they are lowered when failure occurs. Undertaking mastery experiences to overcome difficulties in life will lead to a resilient sense of personal efficacy. For individual's belief in their own self-efficacy is a strong predictor and determinant of successful mastery. According to Bandura et al. (2007) mastery experiences were the strongest source for interpreting information related to self-efficacy.

Another source of interpreting information related to self-efficacy is verbal persuasion. During any social interaction with other individual's verbal persuasion is a main part of the conversation. The art of persuasion can impact upon the level of self-efficacy and therefore goal achievement for each individual. Positive verbal persuasions and interactions can support

and empower individuals to continue with their effort to strive for goal attainment. However, the effectiveness of the persuasion depends on the expertise, the credibility and the trustworthiness of the persuader who is the other person involved in the social interaction (Bandura, 1986).

A further source of interpreting information is vicarious experiences. These experiences are undertaken when an individual observes another individual modelling a skill or behaviour. Many human behaviours are learned through the modelling process. New behaviours are observed as an individual will then use this information as a guide for future action (Bandura et al., 2007). Modelling can serve as an individual motivational factor where information concerning possible positive or negative consequences of particular actions are act out (Schunk, 2008).

The final source of interpreting information is a person's physiological or affective state of mind. An individual's psychological state will affect their confidence whilst they consider whether to or not to engage in an action. Feelings such as self-control, or conversely, anxiety or depression can influence further actions an individual will undertake. Positive ways to increase self-efficacy include improving the emotional and physical well-being and decreasing negative emotional states of individuals. On the other hand, individuals have the capacity to alter their own affective states. Improved self-efficacy beliefs will, influence the physiological state of an individual (Pajares, 2002). Combining and integrating these four sources of

self-efficacy, motivation for activating and sustaining change in the individual can be the outcome (Bandura et al., 2007).

Whilst personal factors come from within the individual, environmental factors reside outside of an individual. Factors such as the community, the family and the physical environment can affect and influence behaviour. Within the environment, incentive motivation in the form of, for example, salary or tax benefits can reward or punish the individual to modify behaviour. Resources, such as social benefits, within the environment can also facilitate change by making new behaviour easier to achieve (McAlister, Perry, & Parcel, 2008).

In order to undertake this present study on this vulnerable group of people who are at risk of homelessness, there is the need to look at risk factors such as environmental, personal and behavioural factors, which can influence the health status in an individual. This entailed a theoretical framework of SCT that also fits in a community or public health perspective. Vulnerable populations such as people who are at risk of homelessness are a community or societal issue (by comparison to an individual issue). They have greater health care needs, their numbers continue to grow and health care inequity exists within vulnerable populations (Shi & Stevens, 2008). The reciprocity between environmental issues affects their thoughts and actions which in turn affect the social environment, thus, their actions and behaviour will influence their thoughts and in turn the environment.

Therefore, the qualitative descriptive design of this study, with a framework of SCT guided the data analysis, findings and discussion in this study. This information has supported the researcher's understanding of the experiences of the participants. SCT was undertaken to intensify the researcher's depth of understanding of the perception and experience of housing support professionals involved in a supported housing program and a maintenance support program for people at risk of homelessness.

In the section below a description of research, paradigms together with an outline of the qualitative design used in this study are summarised.

3.3 Research paradigms

The research process originates from a variety of worldviews within diverse paradigms (Cheek, 1999; Esterberg, 2002). Paradigms can be seen as frameworks holding theories, principles, beliefs and values that can guide individual action related to investigation (Lincoln, Lynham, & Guba, 2011). These beliefs consist of philosophical assumptions concerning the nature of knowledge, objective and perceived truth, what is acceptable, objects and events occurring in the world, as well as who and what is most influential, including the character of people (McMurray, Pace, & Scott, 2004). The philosophical assumptions underpinning paradigms concerning the nature of reality (ontology) and the construction of knowledge (epistemology) cannot be proven or disproven (Davies & Hughes, 2014; Guba, 1990).

The term paradigm refers “to the dominant framework in which research takes place” (Hammond & Wellington, 2012, p. 116). The paradigmatic framework can define how problems are identified, how the research area is to be studied and what will happen to the knowledge after the research study is completed (Hammond & Wellington, 2012; Kuhn & Hacking, 2012). In the past, two paradigms or approaches to research that were debated are qualitative and quantitative paradigms (Creswell, 2013; Leech & Onwuegbuzie, 2007; Liamputtong, 2013; McMurray et al., 2004). These major approaches to research espoused the notion that predominately either a qualitative or a quantitative approach should be undertaken to answer a research question (Creswell, 2013; Creswell & Plano Clark, 2011; Teddlie & Tashakkori, 2009).

The objective, positivist or empiricist paradigm sits within the quantitative paradigm (Creswell, 2013; Esterberg, 2002; Maylor & Blackmon, 2005; McMurray et al., 2004; Sarantakos, 2012). The naturalistic or constructivist paradigm is termed qualitative although this paradigm has also been collapsed into interpretivist-constructivist paradigm, because of the close alignment between the two approaches (Creswell, 2013; Gray, 2009). The qualitative and quantitative paradigms have different assumptions about the underlying nature of reality and knowledge that informs the research phases (Creswell & Plano Clark, 2011; Esterberg, 2002; Lincoln et al., 2011; Sarantakos, 2012). Both qualitative and quantitative researchers use empirical observations to address research questions for a comprehensive,

meaningful and credible understanding of a phenomenon (Johnson & Onwuegbuzie, 2004; Quinn Patton, 2002).

Historically, the decision about undertaking research informed by either paradigm depended upon individual researchers' philosophical suppositions, beliefs, the nature of reality or existence (ontology) and how they understood what constituted this knowledge (epistemology) (Maxwell, 2013; Maylor & Blackmon, 2005; Wahyuni, 2012). The relationship that exists between the participant and researcher is viewed differently epistemologically within each paradigm (Clough & Nutbrown, 2012; Creswell, 2013; Morse, 2005; Sarantakos, 2012). Currently, researchers accept that the choice of research methodology and designs is primarily governed by what research design is most appropriate to answer the research question (Durand & Chantler, 2014). For the purpose of this study, a more detailed description of the qualitative paradigm is outlined below.

3.3.1 Qualitative paradigm

Within the qualitative paradigm, a range of influences exist, one of these is constructivism. The constructivist ontological assumption is that reality is subjective with multiple layers voiced by the research participants (Creswell, 2013; Lincoln et al., 2011). Knowledge is established through meanings attached to the phenomena that are being studied (Krauss, 2005). Charmaz (2014), reasoned that constructivism is used by

researchers to construct meaning and “their interpretation of the studied phenomenon is itself a construction” (p. 187). Although the terms constructivism and social constructionism have been used by researchers as interchange terms, particularly by Charmaz (2014), then used under the generic term ‘constructivism’, there is a difference. In Constructivism the individual is viewed as constructing and experiencing the world through their own cognitive processes whereas social constructionism has more of a social focus, not an individual focus (Young & Collin, 2004).

There is no objective reality or truth for the individual with a constructivist view as individuals within their own social worlds create or construct their own reality (Esterberg, 2002; Lincoln et al., 2011; McMurray et al., 2004; Sarantakos, 2012). Therefore, multiple realities can exist which are made up of reality for participants, the researchers and the reader. Constructivist researchers try to understand how individuals create their own worlds and make sense of their own world, reporting on these individual realities through their own voices, interpretations and meaning (Creswell, 2013; Lincoln et al., 2011; McMurray et al., 2004). Furthermore, meaning is “not discovered but constructed... by human beings as they engage with the world they are interpreting” (Crotty, 1998, pp. 42-43).

In a constructivist paradigm the researcher works within an interpretivist epistemology (Sarantakos, 2012). This involves describing and trying to understand socially constructed realities, generating knowledge about a

social phenomenon, this is often done by the phenomena being interpreted and observed (Lincoln et al., 2011). Through the use of inductive reasoning, qualitative research focuses on individual meaning and interpreting complex situations (Creswell, 2013). Researchers within this paradigm take the part of the emic or insider perspective to generate knowledge concerning the socially constructed reality of the individual's experience (Hennink, Hutter, & Bailey, 2010; Lincoln et al., 2011; Mertens, 2009). Theoretical constructs and theories can be produced which give insightful and comprehensive descriptions, narratives and an understanding of the phenomena being researched (Neuman, 2011).

The researchers within this constructivist paradigm rely on qualitative data collection methods to enable a richness and depth of understanding of the participants within a study. The researcher is the instrument of data collection. The researcher generates the questions asked of participants in interviews and or focus groups; recording notes; making observations and reflecting on the process. By undertaking these activities, the researcher ensures the complexity, depth and richness of phenomena are fully explored (Borbasi & Jackson, 2008; Creswell, 2013; Magilvy & Thomas, 2009; McCaslin & Scott, 2003). In addition, qualitative research takes into account the unique and dynamic aspects of the experience of human behaviour, allowing the experience to be analysed and structured in a holistic way by exploring and acknowledging the dimensions of the

subjective experience (Grove et al., 2014; Higgs, Titchen, Horsfall, & Bridges, 2012; Taylor, Kermode, & Roberts, 2006).

As part of viewing the human experience holistically, the researcher needs to be aware of their own values, attitudes and beliefs underpinning their ethical, theoretical constructs and basic philosophical perspectives whilst undertaking enquiry. This is known by the term axiology (Banister, Bunn, & Burman, 2011; Hesse-Biber, 2013; Hiles, 2008). Within constructivism, the researcher discusses their own biases and interpretations, having an understanding of the role of beliefs and values (Creswell & Plano Clark, 2011). Additionally, the researcher's position concerning the choice of the problem, the theoretical framework, data gathering and analysis methods are identified (Lincoln et al., 2011).

One traditional approach to qualitative research that is seen in the constructivist / interpretivist paradigm is phenomenology. The philosophical movement and psychology which dates back to the early 20th century, underpins the history of Phenomenology. Philosophers that have been integral to the beginning of descriptive phenomenology, which was related to consciousness and the meaning of the individual's experience, include Husserl and Merleau-Ponty (Liamputtong, 2010; Reiners, 2012). Others that emerged from this movement explored interpretive/hermeneutic phenomenology which aims to explore how life experiences are interpreted include Heidegger and van Manen (Liamputtong, 2010; Dowling, 2007).

While phenomenology provides an in-depth understanding of the meaning of the phenomenon, it neither explains how the phenomenon came into existence nor does it offer any possibilities for examining the actions or interactions between the phenomenon and other people. This limitation would tend to suggest that phenomenology might have limited applicability for the researcher in interpreting complex interactions between clients, other members of the health care team or other professionals involved in their care. Thus, a qualitative descriptive approach was chosen as the research design for this current study.

3.3.2 Qualitative descriptive design

Liamputtong (2013, p. 12), advocated that researchers should “embrace methodological diversity” and “methodological pluralism” as knowledge can be generated from varied theories and sources through diverse research. The use of certain methods irrespective of underlying epistemological and ontological positions will be more suitable to answer research questions, particularly to understand multifaceted social phenomena (Liamputtong, 2013). In support of this research diversity, (Flyvbjerg, 2011) concurred that research is “problem –driven and not methodology-driven” (p.313).

Generic qualitative designs have encompassed terms such as qualitative descriptive, descriptive exploratory and interpretive descriptive (Brink & Wood, 2010; Sandelowski, 2000; Thorne, Kirkham, & MacDonald-Emes, 1997). Caelli, Ray, and Mill (2003), defined generic qualitative research “as

that which is not guided by an explicit or established set of philosophic assumptions in the form of one of the known qualitative methodologies” (p.3). A Qualitative descriptive approach has been in use for a number of years. Sandelowski (2010, p. 78), described this design as being an “eclectic” method not invented by one person. More recently, qualitative descriptive (or exploratory descriptive) approaches have been seen as one of the most common forms of qualitative inquiry that are being undertaken (Annells, 2007; Whitehead, 2013). The reason for this may lie in the fact that in this approach, methods do not need to be over-methodological which could help bridge the gap between researchers and clinicians (Whitehead, Dilworth, & Higgins, 2016).

Descriptive qualitative methods allow for various approaches to research and as previously mentioned, researchers are not guided by an established philosophical underpinning. Researchers in a number of reported research studies have used the terms descriptive, exploratory qualitative or use descriptive qualitative as the method or simply have stated that ‘a qualitative design was used’ (Algozo & Peters, 2012; Crowe, Whitehead, Jo Gagan, Baxter, & Panckhurst, 2010; Daiski, 2007; Manias, Aitken, & Dunning, 2005; McKenna, Bogossian, Hall, Brady, Fox-Young, & Cooper, 2011; Tse, Lloyd, Petchkovsky, & Manaia, 2005).

In undertaking qualitative descriptive research, researchers remain closer to the surface of the participant’s words than researchers undertaking

ethnographic, phenomenological, narrative or grounded theory studies (Sandelowski, 2000). Although remaining closer to the surface, the meanings that the participants attribute to the facts still need to be conveyed in a correctly, coherently and functional manner. The qualitative descriptive researcher aspires to give as thorough an analysis as possible without losing the actual meaning of the words or the event, thereby reflecting and connecting to the reality of the participants. The data can then be considered based on the focused and actual reality for the individual (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000; Sullivan-Bolyai, Knafl, Tamborlane, & Grey, 2004).

Qualitative descriptive approaches do share a number of common elements with other qualitative methods. Qualitative descriptive designs are used in order to attempt to understand complex experiences that cannot be accurately or precisely measured. Qualitative designs are used to draw out and capture the personal realities of people through their individual understanding of their stories and life events (Brink & Wood, 2010; Lincoln & Guba, 1985; Merriam & Tisdell, 2015; Parse, 2001; Polit-O'Hara & Beck, 2006).

Additionally, qualitative descriptive studies can be informed by various methodologies, and data analysis methods (Polit-O'Hara & Beck, 2006; Sandelowski, 2000). For example, Williams (2004) used a qualitative descriptive design informed by a descriptive phenomenological method of

theme development. In this study, the experience of clients with comorbidity without a comprehensive 'lived experience' is described. Qualitative descriptive design can also have the nuances of a grounded theory approach with the aim of interpreting and presenting the original data rather than producing a theory of the phenomenon in question when using purely a grounded theory design. For example, Pieters, Heilemann, Grant, and Maly (2011) described the experiences of older women's barriers to care for breast cancer using a qualitative descriptive research method guided by grounded theory. Semi structured, individual interviews were used and the analytic approach was constructivist grounded theory.

Other methods used in qualitative research such as constant comparison, theoretical sampling and phenomenological reflection have also been used in a number of qualitative descriptive research studies (Lin, Pang, & Chen, 2013; Parse, 2001; Polit-O'Hara & Beck, 2006; Sandelowski, 2000). The use of purposeful, small size sampling and the richness of the data from the participants is more important than quantity. Data collection using semi-structured open-ended individual interviews or focus groups; and content analysis become the method of choice for penetrating and organising the data (Ezzy & Liamputtong, 2005; Isaacs, 2014; Sandelowski, 2000).

In qualitative research the need to focus on differences related to who or what is being sampled, the treatment of the data, how data are interpreted and assessment of rigor is more important than the name that is given to

the research approach (Caelli et al., 2003; Sandelowski, 2010). The use of qualitative descriptive design as a method has been seen as one which could encourage inter-professional research discourse as other forms of qualitative design, which have a philosophical underpinning, or discipline specific underpinning could restrict multi-disciplinary understanding. As mentioned previously, there are no philosophical pre-assumptions which can limit or hinder understanding for people who are involved in the research (Magilvy & Thomas, 2009). In addition, qualitative descriptive design can be used as a medium for treating research methods as living, changing and adaptive entities, not necessarily being tied to one simple classification or philosophical perspective (Sandelowski, 2010). Similarly, because of being a generic design, qualitative descriptive method can be used by clinicians, administrators as well as participants involved in being researched (Isaacs, 2014; Sullivan-Bolyai et al., 2004).

Qualitative descriptive design is a practical approach when close depiction and rich description through inductive analysis of phenomena are required (Merriam & Tisdell, 2015; Neergaard et al., 2009; Sandelowski, 2000, 2010). Although a study has been labelled as having used a 'descriptive method', both descriptive and interpretative designs in a study can be seen as being on a continuum with elements of both interpretation and description can be included (Elliott & Timulak, 2005; Marshall & Rossman, 2010; Punch, 2013).

There are, however, a number of criticisms concerning qualitative descriptive design, some of which are also criticisms of qualitative research in general. Firstly, it has been suggested that it is too simplistic and lacking rigour on the basis of not having philosophical underpinning and following a more traditional methodology (Milne & Oberle, 2005; Sandelowski, 2000). In order to defend the rigour of the qualitative descriptive method the researchers must be meticulous in defining: the stages of the research process; the researcher's interests; the research question and the purpose of the study (Guba, 1990).

Secondly, usually a small group of participants are involved, which can challenge the generalisability of the findings. Although this is a general criticism of qualitative naturalistic inquiry i.e. statistical generalisability and transferability, the in-depth analysis of qualitative descriptive data allows for a rich description and understanding of the small group and the experience in question (Polit-O'Hara & Beck, 2006).

Thirdly, even though qualitative description stays close to the data and to the surface of the words, the data are still filtered through the researcher which can lead to some preference or bias in reporting the data (Shenton, 2004; Wolcott, 1994). In an attempt to overcome this bias, as for all qualitative studies, the maintenance of reflexive materials (such as the critical examination of writing and construction of text representations), relationship awareness, critical self-reflection and supervision of the

researcher is imperative for the qualitative descriptive researcher (Hein, 2004; Hewitt, 2007; Hunt, 2009; Shenton, 2004). For more information on rigour, please refer to the section in Chapter 4, Methods.

Finally, qualitative descriptive research is not theory based or underpinned by philosophical perspectives (Milne & Oberle, 2005; Sandelowski, 2000). Although descriptive qualitative studies do not have the philosophical underpinnings of traditional qualitative research methods, many descriptive qualitative studies incorporate theoretical frameworks to provide the context for the data analysis and to provide the researcher and the reader with deeper understandings of the theoretical /conceptual context of the study (Brink & Wood, 2001; Polit-O'Hara & Beck, 2006; Sandelowski, 2000; Schneider, Whitehead, LoBiondo-Wood, & Haber, 2012; Whitehead et al., 2016). Theoretical frameworks bring together assumptions concerning phenomena of interest, allowing a shared understanding of how the theory is enacted in practical situations (Creswell & Plano Clark, 2011).

An example where the use of qualitative descriptive design was underpinned by a theoretical /conceptual framework has been seen in the research by (Sword, Busser, Ganann, McMillan, & Swinton, 2008). The findings from this study provide a deep understanding of women's care-seeking experiences after referral for postpartum depression. This study used an orienting framework to demonstrate how health services utilisation would assist these women at this vulnerable time. Within this framework,

behaviour of an individual is influenced by personal, situational and health care policies. Barriers and facilitators of care seeking emerged in the data from the interviews.

A further example of a qualitative descriptive exploratory design which was underpinned by a theoretical perspective is seen in a study by Dempsey (2008). In this study, Parse's "human becoming" underpinned theory generation in order to provide an explanation of 'feeling confined'. In the study men who were incarcerated in a mental health unit in a security prison were explored. Pilkington (1999) also used Parse's "human becoming" to explore quality of life after a stroke from the patient's own perspective. Both these studies were underpinned by the inclusion of a theoretical perspective as the researchers focused on health as a lived experience, which informed the objectives of the study. This also provided an in-depth understanding of the data. LoBiondo-Wood and Haber (2014) argued that having a theoretical framework strengthens a study and gives confidence to the researcher in providing evidence in the findings.

Caelli et al. (2003) suggested that researchers who are using a generic approach to their research need to: make their theoretical position clear by describing their own motivation in undertaking the study and at a minimum, identify their affiliated discipline as well as any assumptions they have concerning the topic area including the rationale for undertaking the study. Therefore, the researcher needs to ensure congruence between the

methodology and the methods employed, and establish rigour that is “informed by a set of assumptions, preconceptions and beliefs” (p. 16). In addition, generic researchers need to make a clear identification of the analytic lens through which data are examined by making their “own assumptions clear, as well as ensure that the methods they choose are congruent with those assumptions” (Caelli et al., 2003, p. 18). How people construct their worlds, what meaning the individual attributes to the experiences and how they interpret their experiences is the phenomenon of interest in this study (Merriam & Tisdell, 2015).

Exploring this phenomenon will provide an understanding about how individuals at risk of homelessness make sense of their own experiences within a housing support program (HSP) and a maintenance support program (MSP). Qualitative methods were used in this study in the form of semi-structured interviews. Additionally, focus group interviews were undertaken with housing support professionals involved in referring clients to the housing support program. Semi-structured interviews were also used to explore the views of respondents in the maintenance support program.

The overall aim of the study was to identify and describe the experiences from the clients and stakeholders’ perspective in a housing support program and maintenance support program. The use of qualitative methods to answer the research questions fitted within this paradigm. A

social constructivist approach was the underlying epistemology and framework that guided the whole study. In order to gain an understanding of the perspectives of people involved in this study and as the data in this study is not generated or interpreted on the basis of existing theories or knowledge, an underlying theoretical framework (SCT) (Caelli et al., 2003; Carter & Little, 2007; Crotty, 1998) was incorporated into this study. The evidence from the data was integrated with this theoretical framework to help describe and explain homelessness and allowed an interpretive approach to the individuals' social reality (Caelli et al., 2003; Grove et al., 2014; Jabareen, 2009; Polit-O'Hara & Beck, 2006).

3.4 Summary

In this chapter, an overview of the methodology of this study has been presented. At the beginning of the chapter an overview of the descriptive lens concerning engagement with the data, has been discussed, in the section on theoretical framework, incorporating the Social Cognitive Theory. Finally, research paradigms focusing on qualitative paradigms, and in particular, a qualitative descriptive framework were discussed.

The research methods, that is, the techniques, tools and procedures for gathering data are discussed in Chapter 4. In Chapter 4, issues of trustworthiness including rigor and quality of the evidence will be addressed. In conclusion, the concerns about the researcher's own assumptions, preconceptions and beliefs will be articulated in the chapter.

CHAPTER 4: METHODS

4.1 Introduction

In Chapter 3, an explanation and how this study is situated within a qualitative epistemological and ontological framework, is given. In this chapter, the processes and procedures used to conduct this study are provided. The research purpose, aims and questions that were used to identify the most appropriate methods for this study are articulated (Creswell & Plano Clark, 2011). The methods used to explore the experiences of people at risk of homelessness, in 1) a Housing Support Program (HSP) and 2) a Maintenance Support Program (MSP). Ethical considerations including, how participants were selected and recruited are discussed; as well as how the data was collected and analysed. The conclusion to the chapter includes a discussion about the rigour and quality of the evidence offered within the study.

4.2 Study purpose

The purpose of the study was to explore the experiences, expectations and perceptions of stakeholders (clients, case managers, housing support professionals and health professionals) who were involved in two support programs for people who are at risk of homelessness. The stakeholder experiences were investigated in order to uncover how these support programs functioned, to explore how they were supportive to clients and to

provide an overall assessment of each program as described by the perceptions of the stakeholders.

4.3 Research aims

The objective of the study was to explore a housing support program and a maintenance support program targeting people at risk of homelessness: the aims were to:

- Identify and describe clients who used support services available for people who are at risk of homelessness.
- Explore the stakeholders' experiences and perceptions of the support provided within these programs.
- Identify issues that impeded or facilitated the management and support of the clients within these programs.

4.4 Research question

The research questions addressed in this study were divided into the two programs studied:

1. What are the experiences of clients, case managers and housing support professionals involved in a Housing Support Program (HSP)? The specific research questions were:

- What are the experiences of clients using the HSP?
- What are the experiences of case managers working in the HSP?

- What are the experiences of the referral process of those who referred clients to the HSP?

2. What are the experiences of clients, case managers and health professionals in a Maintenance Support Program (MSP)? The specific research questions were:

- What are the experiences of the women in the MSP?
- What are the case managers' experiences of working with the women in the MSP?
- What are the experiences of health professionals working with the women in the MSP?

4.5 Research design

A qualitative descriptive design was used in this study which involved both in-depth individual face-to-face interviews and focus group discussions (Bryman, 2015). Qualitative researchers use a range of data gathering and analysis methods (Cleary, Horsfall, & Hayter, 2014). One of the most common data collection techniques in qualitative descriptive approaches is the use of face-to-face interviews. This type of interview allows the researcher to gather participants' opinions, attitudes and views of an area of interest, thereby creating a basis to engage with participants (Schostak, 2005). When the researcher has adequate information about the phenomena to prepare questions, but cannot envisage possible responses, a semi-structured format for interviews is deemed appropriate (Richards &

Morse, 2012). The use of semi-structured interviews for the individuals (the clients, the case managers and health professionals) were undertaken to give perspectives about their experiences. Kvale and Brinkmann (2009), described the use of interviews as a way of enabling in-depth data collection which reflects an individual's experience, attitudes, opinion and feelings. In addition, the interview process provides a means of conversation in an attempt to allow topics to emerge (Gilham, 2005; Quinn Patton, 2002).

The focus group interviews were the other form of data collection. The use of a focus group interview with people who referred clients to the HSP allowed specialised participants (health and housing support professionals) to discuss their perspectives on the HSP in a supportive group interaction. Interaction, together with a component of flexibility and adaptability, has been shown to provide positive results in this form of data collection. (Krueger & Casey, 2000; Mansell, Bennett, Northway, Mead, & Moseley, 2003; Schneider & Whitehead, 2013). Furthermore, focus groups can involve a wide range of discursive practices including formal structured conversations with people on a clearly limited topic to less formal and open-ended conversations in large and small groups. They can also serve various purposes from gathering empirical data to pedagogical, educational purposes. The focus in the group can be tightly controlled and dictated by the interviewer or constructed by the dialogue of the participants within the group (Kamberelis & Dimitriadis, 2013).

4.5.1 Participant Selection

When undertaking research with a vulnerable population, researchers need to be cognisant of specific and sensitive care. Quest and Marco (2003) consider that vulnerable groups are made up of people with social vulnerability. In particular, this includes the homeless, the unemployed, sex workers, including ethnic and religious minorities. Similarly, vulnerable people include those that are “susceptible to coercive or undue influence” such as the mentally disabled or those who are “economically or educationally disadvantaged” (Stone, 2003, p. 149). Therefore, avoidance of situations in research that could actually create harm or coercion for a vulnerable group is necessary (Stone, 2003).

The homeless population may, not only grapple with tenancy issues and accommodation problems, but also with a mental health diagnosis or having to contend with trauma, grief and interpersonal issues (Cleary, Horsfall, & Escott, 2014). Undertaking research with this vulnerable population gives clinicians more of an understanding concerning the lived experience of people with mental illness, the situations they experience, people they encounter and service provision offered (Horsfall, Cleary, Walter, & Malins, 2007).

Although undertaking research with this population can elicit responses of feeling stigmatised, socially excluded, trauma and marginalisation, this research may possibly also include experiences of being able to change,

meeting friends that they have encountered with similar issues and this may perhaps instil hope as a result of encounters with appropriate services (Cleary, Escott, Horsfall, Walter, & Jackson, 2014).

When researchers undertake research with mental health consumers, the overall reason should include improvement in the mental health of the individual and services provided as well as understanding clients from new perspectives (Horsfall, Cleary, Walter, & Hunt, 2007). In this study, the voices of a group of vulnerable individuals who have been involved in a housing support program and a maintenance support program have been heard. They were able to articulate their experiences of the programs, together with the various people involved in the provision of the programs. Individual considerations were taken into consideration and further discussed in section 4.3.5.

4.5.1.1 Housing Support Program (HSP)

The participants in this research study comprised of HSP clients, case managers and housing professionals who referred clients to the HSP. Nine clients in the HSP formed a purposive convenience sample. They were selected and recruited for the study by their case managers. Inclusion criteria for the clients were that case managers had assessed clients as being:

1. in community and public housing
2. at risk of or experiencing homelessness;

3. aged over 45 years (age stipulated by the program case managers as there was a need to capture opinions of an older age group);
4. eligible to be interviewed by their HSP case manager;
5. able to understand, comprehend and communicate in English, and
6. able to provide informed consent.

The only inclusion criterion for case managers, to be involved in the study, was that they had participated in long-term management of clients for a period of three months. As well as this, people within government housing organisations who had referred clients to the HSP, (no time was defined), were eligible to participate in a focus group interview.

4.5.1.2 Maintenance Support Program (MSP)

The participants for this study consisted of clients who attended the MSP, case managers and health care professionals who worked in the MSP. A total of six case managers and health professionals who attended the MSP were recruited for the study. Also recruited were fifteen clients who attended the MSP on a regular basis, and these participants formed a convenience sample. Inclusion criteria for the clients were that they were those:

1. deemed by the case manager to be eligible to be interviewed;
2. able to provide insight into their experiences in attending the MSP;

3. able to understand, comprehend and communicate in English;
4. aged 18 years and older, and
5. able to provide informed consent.

4.5.2 Participant recruitment process for the HSP

4.5.2.1 HSP clients

The HSP case managers were asked to identify clients who were eligible for the semi-structured interviews. They requested their permission on behalf of the researcher to telephone them to arrange a convenient time and place to meet for the face-to-face interview of approximately sixty minutes in duration. A Participant Information Sheet (See Appendix 1) was given to the clients at time of the interview they were asked to read this sheet that explained the procedures and purpose of the research as well as the voluntary nature of participation, including the right to withdraw from the study at any time. If they agreed to participate, they were requested to sign a Consent form (See Appendix 2).

4.5.2.2 HSP Case Managers

All HSP case managers were approached by the researcher and invited to participate in the study. Those who agreed to participate were given an explanation about the study, and a time and place to conduct a face-to-face interview was arranged. An Information Letter was given to participants they were asked to read this letter which explained the procedures and

purpose of the research as well as the voluntary nature of participation, including the right to withdraw from the study at any time. (See Appendix 3). If they agreed to participate, they were requested to sign a Consent form (See Appendix 4).

4.5.2.3 Housing support professionals

Recruitment for the focus group was undertaken from a pool of candidates who provided their contact details in a previous study (McMaster, Hawley, Fletcher, Gillett, McDermott, & Middleton, 2010). A letter was mailed to the housing support professionals to give their contact details if they were interested in participating in a focus group interview concerning their experiences with the HSP at a time and date convenient to them. Prior to commencing the study, all participants received a Participant Information Sheet (Appendix 5) which explained the procedures and purpose of the research as well as the voluntary nature of participation, including the right to withdraw from the study at any time. Once participants agreed to be involved in the study, they were asked to sign a Consent Form (Appendix 6).

All participants (including the clients, case managers and health professionals) were assured of anonymity and privacy of all data including the de-identification of all data obtained from the interviews and focus group discussions.

4.5.3 Participant recruitment process for the MSP

4.5.3.1 MSP clients

The MSP case managers were asked to identify clients who were eligible for the semi-structured interviews. They requested their permission on behalf of the researcher to telephone them to arrange a convenient time and place to meet for the face-to-face interview of approximately sixty minutes in duration.

Each client who participated in the interview was given \$30 as a token of appreciation (cash was suggested by case managers as this was the preferred option based on their past experience with the clients, as it was preferable to a food voucher. This token of appreciation was considered as a reinforcement of autonomy and responsibility of the individual and not seen as a form of control. A Participant Information Sheet (See Appendix 7) was given to the clients at time of the interview. They were asked to read this sheet that explained the procedures and purpose of the research as well as the voluntary nature of participation, including the right to withdraw from the study at any time. If they agreed to participate, they were requested to sign a Consent form (Appendix 8).

4.5.3.2 MSP Case managers and health professionals

The case managers and health professionals were approached by the researcher and invited to participate in the study. The case managers and health professionals were provided with an explanation of the purpose and

nature of the study and given Information letter (Appendix 9). A time and place to conduct the face-to-face interview was arranged and then they were asked to sign a consent form (Appendix 10).

4.6 Data Collection

Data collection for HSP participants consisted of two formats of interviewing, semi-structured individual interviews with the clients and case managers and a focus group interviews with housing support professionals.

Data collection for MSP participants consisted of semi-structured individual interviews with clients, case managers and health professionals.

4.6.1 Interview guide for HSP Clients and case managers

4.6.1.1 HSP Clients and case managers

A semi-structured face-to-face interview, which consisted of open-ended questions, was used to collect qualitative information from both the HSP clients and case managers.

The interview format provided participants with the opportunity to describe in their own words their experiences of being involved in the HSP. The semi- structured interviews consisted of seven questions for clients (Interview Guide – Clients, see Appendix 11); and seven questions for case managers (Interview Guide – Case managers, see Appendix 12).

The clients were asked to describe their experience of being a client; how the case manager helped them to maintain tenancy; the benefits of the

HSP; any changes, which could improve the program; other services that were involved in the HSP and their satisfaction with the program.

The case managers were asked to describe the HSP and why they became part of the HSP; their relationship with referral agencies; challenges/barriers and benefits of being part of the HSP and any changes needed in the HSP. If participants did not naturally address particular areas, follow up questions were asked to provide participants with the opportunity to address all areas. Interview questions were designed with reference to the existing literature on the topic.

4.6.1.2 Housing support professionals

The focus group incorporated a structured group discussion, to explore the perception of the housing support professionals. The focus group commenced by giving a case study that was based upon a typical client in the HSP and was used to add some structure to the discussion (Appendix 13). Then a broad discussion ensued about the general aspects of the HSP and their own experiences of the HSP including identifying goals for the clients of the HSP; strategies to achieve these goals; barriers and challenges to the referral process; benefits of the HSP and recommendations (Appendix 14).

4.6.1.3 Interview guide for MSP Clients, case managers and health professionals

A semi-structured face-to-face interview consisting of open-ended questions was used to collect qualitative information from the MSP clients, case managers and health professionals. The aim of the interview format was to offer participants with the opportunity to describe in their own words their experiences of being involved in the MSP.

The semi- structured interviews consisted of ten questions for the clients (see Appendix 15) and nine questions for the case managers and health professionals (see Appendix 16). The focus of the interview questions for the clients comprised of describing their experiences in the MSP. The services in which they had been involved. The activities in which they had been involved. The support from the case managers / health professionals that they had received. Their satisfaction with the services and activities; the benefits of the MSP; their satisfaction with standards of living, their own health, accomplishments in life, in their individual personal relationships, support from others, in the community, as well as their safety, security, and improvements that might be needed to be made to the MSP. The specific structured question (Q10 in Appendix 15) for the clients was considered background information and enabled further questions related to how or if, in any way, being part of the MSP changed the participants' satisfaction with their present situation.

The interview questions focused on a description of their role for both the case managers and health professionals. They were asked about the type of work that this involved; their relationship with referral agencies; benefits of the MSP; challenges/limitations/barriers to working within the MSP; any changes needed for the MSP. If participants did not naturally address particular areas, follow up questions were asked to provide participants with the opportunity to address all areas. The existing literature on the topic helped with the design of the interview questions.

4.7 Ethical consideration

This study received approval from the Human Research Ethics Committee of the University; for the Housing Support Program: Ethics approval number: N200708-69 and was granted in 2008 (see Appendix 17). The Maintenance Support Program received Ethics Approval number: N201066 and was granted in 2011 (see Appendix 18). Data collection only commenced after obtaining Ethical approval.

4.7.1 Participant information

All participants were provided with information concerning the study and the format of the interview. This included information concerning the demands of the participant; being able to withdraw without penalty from the study at any time. An explanation that there would be no consequences of withdrawing from the study. As well as that there would be de-identification of participant personal information; publication of research in reports;

information concerning the researcher and supervisors including, contact information of the Chair of the Human Research Ethics Committee if participants had any concerns or complaints.

4.7.2 Informed consent

After the participant had read, the Participant Information Sheet and questions relating to the study were answered, the researcher asked each participant to sign a consent form prior to each interview. The consent form included the following details: understanding and questions pertaining to the study after reading the Participant Information Sheet; agreement to participate in an audio-taped interview; the time the interview would take; being able to withdraw at any time without any adverse consequences; collection, processing and reporting of information for research purposes; anonymity of data; publication of de-identification of data; names and details of researcher and supervisors.

4.7.3 Confidentiality, privacy and anonymity

Participation was voluntary and participants were advised that their contribution would be kept private confidential. The project adhered to ethical requirements of the National Health and Medical Research Council (National Health and Medical Research Council, 2007). In order to maintain confidentiality, the research team were the only people to have access to the data which was stored securely. In addition, all electronic data would be

password protected. All identifiable data with participant's names were de-identified.

4.7.4 Data storage

Guidelines outlined in the National Health and Medical Research Council (2007) have been followed. Data were de-identified and are stored in locked cabinets in a secure room of the researcher. This data includes all paperwork relating to the study including interview transcripts. Data stored in files on the researcher's computer is password protected. Information will be retained for five years following publication, after which electronic files will be deleted and paperwork shredded.

4.7.5 Individual considerations

At the beginning of the interview, time was given for introductions, background information and setting the scene of the study before formal interviews took place. Although it was considered that the groups would be at low risk of discomfort from an interview, as part of the ethical conduct of this study which involved a vulnerable population, a counsellor was available should an individual suffer any degree of anxiety during the interview. In addition, if the participants wanted to leave the interview or have time away from the interview, the interview would be adjourned until they were either able to continue or another time would be selected if the participant consented. No incidents occurred which needed this action to

be taken. In addition, no unforeseen situations arose during the research process and all required ethical guidelines were followed.

4.8 Data analysis

Sandelowski and Barroso (2003), described research findings being on a continuum of transformation of data from description to interpretation occurring throughout the data analysis process. Two of the most common qualitative approaches used in data analysis and in qualitative descriptive studies are content analysis and thematic analysis (Vaismoradi, Turunen, & Bondas, 2013). Data analysis within this qualitative descriptive study used thematic analysis based on Braun and Clarke (2006).

Thematic analysis incorporates both manifest (analysing the content close to the data) and latent (interpretation of the underlying meaning, looking for relationships) analysis was used in this qualitative descriptive study. This is considered the most appropriate analysis to use for qualitative descriptive design method and is similar to other forms of qualitative analysis (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005; Sandelowski, 2000).

In fact, the analysis of “the latent level goes beyond the semantic content of the data, and starts to identify or examine the underlying ideas, assumptions, and conceptualisations... informing the semantic content of the data” (Braun & Clarke, 2006, p. 12). As this study involved a diverse set of interviews (two different settings, various stakeholders) thematic analysis

was undertaken to broaden and increase an understanding of the stakeholder experience within a housing support program and a maintenance support program. Thematic analysis has been considered more appropriate than content analysis when a detailed, rich and complex account of the data is needed (Braun & Clarke, 2006).

Braun and Clarke (2006), described six steps within thematic analysis involving a recursive process in that steps were repeated as necessary in a cyclical process. The first step concerned becoming familiar with the data, which involved the transcribing process. Within this process, reading then rereading the data occurred with initial ideas being noted. The interview data from the HSP as well as the focus group data and the MSP interview data were re-examined.

To assist in this process, the interview transcripts, focus groups, personal observation notes and diary entries were transcribed verbatim. For organisation of the data sets interviews and focus group data; observation notes and diary entries were coded separately and then compared.

The second step involved generating initial codes. As the coding system developed, criteria for inclusion or exclusion from each code were refined. In order to check reliability and validity, sets of interviews were cross-coded by one supervisor and these codes were discussed. The coding can be more data driven (inductive) or theory driven (deductive) (Braun & Clarke, 2006). The first stages of analysis in this study were data driven whereby

codes were dependent of the data and aiming to stay close to the participant meanings.

The third step involved searching for and developing themes from these codes. This process continued until all text had been coded and no new themes emerged. This analysis involved a broader examination of the themes, rather than looking at the codes separately. An initial thematic mind map was generated. All data extracts were coded relating to separate themes. The fourth step related to reviewing the themes from step three then combining some of the themes, refining and separating other themes. Some themes were then discarded while again checking the coded extracts.

The fifth step incorporated ongoing analysis to refine each theme and the narrative involved to generate clear sub-themes, which underpinned the major theme. These sub-themes were identified as themes- within-a-theme and helped with the hierarchy of meaning within the data (Braun & Clarke, 2006). Within this interpretive analysis, the concepts relating to Social Cognitive Theory (SCT) [as described within Chapter 3] provided a specific context. SCT focuses on the personal, environmental and behavioural factors that influence an individuals' choice of pathway in life in their present circumstances. For example, an individual is affected by their current environment, being homeless, impacting their thoughts and actions. An opportunity to reflect on their situation may be provided, by being part of

a housing or maintenance support program, thereby influencing their intended and subsequent behaviour. The theoretical framework of the SCT (Bandura, 1977, 1984, 1986) has given some illumination to this data, to make sense of the data by organisation of thoughts within the data (Green, 2014; Maxwell, 2013).

This stage involved re-examining the whole study and identifying what the data eventually captured. Refinement of the story of the experiences of the stakeholders within the housing program and the maintenance support program led to looking at both programs separately and having one overarching theme. Underpinning this theme, there were enablers and constraining aspects and dimensions related to the major theme. The final step involved the analysis of the data and the writing of the report. This step refers to going beyond data description, into a more interpretive narrative and analysis (Braun & Clarke, 2006).

4.9 Rigour qualitative data

In all qualitative studies, the rigour of the research is concerned with reliability and validity of the research which includes the appropriateness of the qualitative method and the visibility and accountability of the research data (Davies & Dodd, 2002; Lincoln & Guba, 1985). Credibility, dependability, confirmability and transferability as outlined by Lincoln and Guba (1985) are standards of displaying trustworthiness in qualitative designs and were used to ensure rigor in this study.

Credibility means producing data from the research that is convincing or reliable from the viewpoint of the people involved in the research. The data must be able to capture and describe an emic or insider (participant) point of view, as well as remaining true to the findings (LoBiondo-Wood & Haber, 2014; Milne & Oberle, 2005). In the context of this study, emic refers to the organisation and interpretation of data provided by the people being studied (Liamputtong, 2010). The researcher for this study checked the transcripts of the interviews with the audiotapes to ensure no discrepancies existed between the audio version and the written word. A consensus of the categories being developed was reached through agreement with another researcher. Regular meetings were held with the researcher's supervisors, who challenged any interpretations relating to the formation of categories, sub-themes and themes. This type of peer inspection throughout the data analysis stage assisted in strengthening the credibility of the emerging findings of the study.

Transferability describes whether a study's findings and conclusions can be transferred to other similar situations. Therefore, an in-depth description of where the study is undertaken, that is, the context of the study is necessary to enable "transferability inferences" (Shenton, 2004, p. 69). Lincoln and Guba (1985) recommended the need for "a full description of all the contextual factors impinging on the inquiry", thereby allowing readers of the phenomena under investigation to decide whether conclusions are transferable to other settings or situations (p. 65). The use of a 'thick

description' of the research field experiences as opposed to a thin description also allows for the explicit context of the research (Holloway, 1997).

Dependability involves the ability to show that the findings of a study are able to be repeated and are consistent, allowing an evaluation of the data to confirm accuracy of the findings. This accuracy will confirm whether the interpretations and conclusions are or have been supported by the data (Lincoln & Guba, 1985).

Confirmability involves the use of an audit trail of the research path, including the decisions of research design, data collection and the stages of management, analysis and reporting of the data. This trail also encompasses raw data such as field notes, how themes, sub-themes and concepts were constructed and synthesised; personal reflexive notes and observations (Lincoln & Guba, 1985; Malterud, 2001). In this study, the role of the second researcher was to confirm emerging categories, sub-themes and themes from the raw data. Information has been provided not only about the way in which the data were collected but also about the process used for analysis and interpretation of the data. The researcher kept memos regarding developing categories, sub-themes and themes. These memos formed an audit trail of how the researcher made judgements and decisions throughout data analysis and interpretation.

4.10 Reflexivity

The use of reflection has been considered a necessary component of qualitative research because researchers need to reflect and undertake self-scrutiny on their own values and beliefs. Reflexive researchers also try to understand the participants' views in the context in which they occurred, making them explicit (Long & Johnson, 2000; McMillan & Schumacher, 2010). The researcher's background can shape the research from the inception of the idea through to choice of method and the report of the findings and conclusions. Therefore, the background of the researcher needs to be acknowledged and whether this may influence the research process and interpretation of the data (Blignault & Ritchie, 2009; Schutt, 2011). For this study, in my case, I have a nursing background and I have not worked clinically for several years and have worked with a vulnerable population in the mental health area. Self-reflexivity incorporates discussion concerning assumptions and experiences of data collection with others, for example, supervisors (Dowling, 2007).

In this study, the use of memos and a diary of events helped the researcher reflect on all parts of the research process, especially interpretation of findings, to remain faithful to the experience of the participants. The process of journal writing support the process of self-reflection and are used to examine and monitor reactions, expectations, thoughts and feelings throughout the research process (Simons, 2009). Also, bracketing

and being aware of one's own assumptions and preconceptions lessens the likelihood of bias being incorporated into the findings (Newton, Rothlingova, Gutteridge, LeMarchand, & Raphael, 2011). In addition, the stereotypical images or negative publications of people who are or have been homeless needed to be acknowledged and then set aside (incorporating bracketing) while writing and being immersed in the findings.

As noted within this section, and within this study, credibility, dependability, confirmability and transferability of the findings were established to support trustworthiness of the findings.

4.11 Chapter summary

In this chapter, the methods undertaken in conducting the study, the expectations and perceptions of the stakeholders who are involved in two support programs for people at risk of homelessness have been presented. The purpose of the study research aims and questions were described. The use of qualitative descriptive design was undertaken. This was an appropriate to research design in order to capture the complexity of two settings and to address the research questions.

Ethical considerations were implemented. Each data collection method has been explained the collation of information concerning various groups within the programs. The use of interviews and focus group interviews concentrated the subjective experiences and perceptions concerning involvement in the programs by all the participants. Thematic analysis was

used to incorporate more interpretation for both programs. This analysis incorporated both manifest and latent aspects. Finally, outlining of the rigor process used to enhance the quality of the evidence completed this chapter. In the following chapter (Chapter Five), the findings of the experiences of participants involved in the HSP program will be reported.

CHAPTER 5: FINDINGS: THE PARTICIPANTS IN THE HSP

5.1 Introduction

In this chapter, the findings of the participants in the Housing Support Program are presented. The demographic profile of the participants, the themes and sub-themes extrapolated from the interviews with the clients, the case managers, and the focus group interviews with housing support professionals who referred clients to the HSP will be presented and supported by using the participants' de-identified quotes.

5.2 Profile of participants

There were three groups of participants within the Housing Support Program (HSP). These participants comprised of nine clients, three case managers and five people who referred clients to the Housing Support Program.

5.2.1 Housing Support Program clients

At the time of the study, there were 83 clients, 13 had refused any form of housing support, two were unwell, and one client had died prior to being rehoused. The remaining 67 clients were in secure housing three months after the initial assessment leaving a potential sample of 67 clients who met the inclusion criteria. Of these 67 client, only nine consented to be interviewed representing only 13% of the clients who were involved in the

Housing Support Program at the time when the interviews took place. The participants in the study ranged in age from 45 years to 83 years (mean=62 years). Seven clients were male and two were female. No participants disclosed that they were from Aboriginal and Torres Strait Islander (ATSI) background. The majority (n=6, 67 %) were born in Australia and the remainder (n=3, 33 %) were born overseas. All clients resided in the City of Sydney. Six of the clients who were involved with the HSP, were newly accommodated and had new tenancies after a long period of homelessness. The other three clients were at risk of loss of tenancy due to squalor.

5.2.2 Housing Support Program case managers

The three case managers who worked within the Housing Support Program were female. Their backgrounds included experience as a social welfare officer, a social worker and a mental health community nurse. They had 9 to 20 years of community work experience between them and from 10 months to 9 years' experience in the organisation. Further demographic data were not collected to protect the identity of the small sample of participants.

5.2.3 Housing support professionals who refer clients to the Housing Support Program

The focus group interviewees consisted of four female participants and one male participant with the mean length of time in their current position of just

over five years. Their current position included mental health community nurse; Housing New South Wales service officer and specialist; Aged Care Assessment Team social worker and general community nurse from Aged Care Assessment Team.

5.3 Thematic findings

Figure 5.1 provides the overarching theme “A life-changing event: I now have a home” from the themes and sub-themes that emerged from the three groups of participants’ data. In the presentation of the findings, the Housing Support Program will be referred to as the “HSP” throughout. Quotations from the participants are indicated by the use of italics. Various irrelevant words and phrases such as *mmm* and pauses have been removed and replaced with ... This indicates words have been omitted from the transcript, however, the meaning of the passage remains intact. Participants have been identified only by the use of pseudonyms. These findings are supported by the participants’ quotes using pseudonyms [C1-9] for clients, [CM1-3] for case managers, and [FG1-5] for focus group participants.

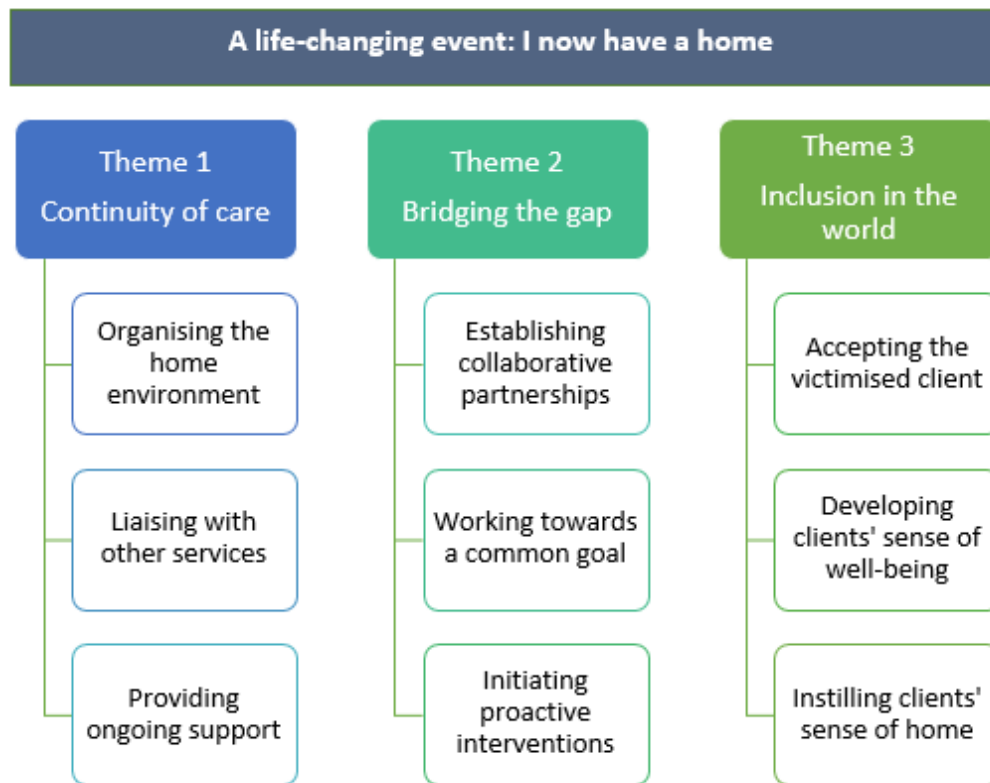


Figure 5.1 Over-arching theme of “A life-changing event: I now have a home”.

5.3.1 Life-changing event: I now have a home

In western society, the importance of having a home is considered one of the fundamental prerequisites of life. The physical needs that sustain life such as food, water, and temporary shelter are important for an individual’s survival. Once these basic needs have been achieved, an individual will then move to securing shelter in the form of a home as a means of providing safety and security. A home can offer protection from a hostile environment and having a home can offer the individual a relaxing and comfortable place and a place free from external judgement and social

demands. Being without this level of protection, individuals can be labelled as homeless and often can be labelled as fringe dwellers or as outcasts, which can stigmatise these individuals. To have personal and social identity within a neighbourhood and the wider community means that an individual must have a secure home. One client reflected upon how being homeless affected his life and the many emotions he felt prior to being counselled by the Program case manager. For this client not having a home and a place for correspondence highlighted the sense of loss, failure and lack of identity.

I wouldn't have got housing in the first place without her [case manager]. She couldn't track me down because they couldn't find me. I was nowhere but everywhere... it was so distasteful to my memory that I don't want to know about it because it's such a shameful part of my life... Being homeless, being ruthless... being a non-event. (C5)

For all participants involved in this study, the overarching theme was that the HSP was a *Life-Changing Event*. All the clients were in secure tenancy for the first time after many years of homelessness. The clients cited many reasons for not being able to maintain tenancy; these included mental health issues; alcohol and other drug issues; physical health limitations; lack of financial management and /or lack of finances; long-term unemployment and lack of family support and involvement. It was not until neighbours, the police or medical services expressed concern for them that contact was made with the HSP. Once the referral process was initiated,

the client was then assessed. If eligibility requirements were met, they were placed in the Housing Support Program.

The interview data from the clients revealed they credited their success and change in life circumstances to the assistance provided by the case manager who was central in helping them achieve, and more importantly, maintain a secure home. Two case managers stated:

Each client is so different; but the main issue is they are not to be homeless again. (CM2)

An underlying aim of housing support is primarily around their tenancy and obviously stopping them from going back into homelessness. (CM3)

The main factors that contributed to this life-changing event for the participants became apparent in the themes: Continuity of care; Bridging the gap and Inclusion in the world.

5.3.1.1 Theme 1: Continuity of care

For the case managers, continuity of care meant being involved with each client over an extended period. Providing this level of care and being there for the client was identified as an important component of the case manager's role. If continuity of care was not provided the case managers indicated that clients would very quickly re-enter a crisis situation.

The clients reported that the three main areas where continuity of care was exemplified were in the sub-themes: organising the home environment; liaising with other services; providing ongoing support.

5.3.1.1.1 Organising the home environment

The clients discussed how the case manager provided many essential items for the home especially when the accommodation was unfurnished. Once these items were obtained, the client were able to create a home environment that supported their daily existence. The clients discussed the ways in which the case manager helped with organising furniture and other household items needed to set up their homes.

A lot of these people need ongoing support... will need some sort of support. If it's not mine, another service within this organisation will provide the support so as to prevent them slipping back into their crisis. We just [need] to be there for them. (CM1)

In spite of having the household items provided to them, they were also aware that these are not their property but for them to use as well as to be taken cared for.

The place didn't come furnished but the case manager furnished it for me with regard to fridge, bed, sofa, well everything that a flat needs... I mean it's not my property... but it's there for me to use... it's there for my convenience. (C3)

Other clients not only needed help with organising general household items but also in cleaning the house. Providing essential toiletries and cleaning

material gave clients the confidence to begin taking over some responsibility in the household. They also acknowledged the need to organise their household and remove items they no longer needed. Taking more responsibility in the home provided to them gave them a sense of ownership and therefore did everything to make this home their own. Unlike other service providers who often did not know the client, the HSP case managers were able to work with individual clients to assist them to manage hoarding issues without detrimental effects.

The people who came before threw things out rather than helped me sort thing out... they got a skip... threatening me of losing the house because of all the boxes... it was literally a hoarder's thing. (C4)

5.3.1.1.2 Liaising with other services

While the clients often saw the HSP as the actual provider of services, in fact the case manager acted as a liaison person to access and organise a broad range of services for the client. There are myriad of healthcare appointments that most people take for granted in their everyday life. For people who have long-term medical problems, who feel powerless and who lack organisational skills, the activities related to appointments to maintain health can be overwhelming. A number of clients indicated that once the case manager provided assistance with appointments and personal support, they were able to attend medical and allied health services for treatment and follow-up.

Well I'm pleased with it [HSP] because they've been very, very helpful, taking me to and from doctor's appointments and services like that. (C1)

One client recalled how missing appointments led him to feel that he was being punished. From his perspective, the punishment entailed being placed on a new waiting list. The outcome for the client was that he missed the next appointment and then the cycle of missed appointments started again. It was not until the case manager intervened that this cycle of missed appointment, punishment, and missed appointment could be broken.

They [case managers] made sure that... I'm getting my dentures next month... I started at least three years ago to try and get them but I keep missing the appointments and they punish me because I miss the appointment. I have to wait so [case manager] took that over. (C2)

Another strategy initiated by the case managers was to facilitate transport to various appointments. Several clients described how this type of organisational support ensured they remembered appointments and they had transport for the many diverse appointments necessary to maintain their independence.

The case manager organised someone pick me up and bring me to the counsellor as I have an interview and then I was taken back home. If they don't have someone around to take me home they give a taxi voucher or say is it alright for me to get home by bus, so all of those things they take into account. (C2)

Liaising with other services also included assisting with financial difficulties. Other clients described how they often got into financial difficulties with their mobile telephone provider. The clients would make limitless telephone calls which they could both not afford and had no money to pay their account. The case manager would then arrange with the telephone provider for the client to receive only incoming calls. While on the surface this appears to be an easy task, in reality the case manager needed to contact various telephone providers to identify the most appropriate assistance program for people facing financial hardship or disadvantage. The case manager would then complete necessary paperwork on behalf of the client and educate the client about this limited service. From the perspective of the clients, these were life-saving actions.

She [case manager] doesn't want me to run an outrageous phone bill... So it's incoming calls and it'll be an absolute life saver. (C3)

Another area where financial management was provided related to direct debt. Clients often had outstanding accounts that they needed to pay fortnightly, but had not put aside the money to cover these bills. The case manager would work with the client to arrange direct debit from the pension to cover these accounts. The outcome of this action was that tenancy was secured because accounts were paid on time and the client's concern was reduced.

... before I get my funds, my pension it's deducted. If I get a bill it's already fixed up out of my pension cheque... So I don't have to worry about it. (C3)

5.3.1.1.3 Providing ongoing support

When a gap in services was identified, the case manager accepted the responsibility for the provision of that particular service. Focus group participants indicated the value for those involved in the HSP was working alongside those working in existing homeless services to ensure clients received organisational support while the clients began the process of settling into their new accommodation. Focus group participants highlighted this lack of support from other organisations as an issue:

There [are] lots of gaps in the support for people and often they go back to that situation again [being homeless] because they didn't have the intense case management and support as our HSP. (FG5)

Similarly, focus group participants described how, in contrast to other service provision, the case managers were able to provide continuity of care. The care for the clients was sustained by the on-going support of that care.

The coordination and consistency of care for so many people are being lost to just a quick fix. Then they've got the same problem six months later. At least with this HSP, it's actually maintaining and continuing the care. (FG1)

Similarly, the case managers were adamant that the clients needed to be helped and supported in understanding what to do about their situation, particularly when other organisations were unavailable.

A lot of them were already [living] in squalor and there was nobody that you could even talk to, to support the clients, to figure out what to do with them. A lot of them had rent arrears, unpaid bills, the places were ill maintained, and when you'd say, look, you need to ring Department of Housing, they'd go, oh, look, I've rung that number and I never get them – it was just too hard for them. (CM2)

5.3.1.2 Theme 2: Bridging the gap

The second theme was 'Bridging the Gap' between services for the client. 'Bridging the Gap' was exemplified in the sub-themes: establishing collaborative partnerships; working towards a common goal; and initiating proactive interventions. Service providers have all clearly established criteria for accepting the clients into particular programs. For example, some criteria stipulate that a client must be within a particular age range or comes from a defined geographical location. Other criteria may focus on mental health issues or medical problems. While many clients will meet the criteria, there are many who do not, and therefore they cannot be offered an assistance package. A case manager supported by the focus group participants indicated that regardless of whether or not the client meets certain criteria the HSP accepted these clients.

There has never been a program that the [specific] client was able to fit into. She's been in other programs but it's like 'she really shouldn't

be because this doesn't fit her. There are no other programs'. We have to have her as a client, as a preventative measure because she is so at risk of losing her tenancy. (CM2)

Many of the clients accepted by the HSP had either been rejected by other organisations or accepted then later rejected by the same organisations. Reasons included clients' behavioural issues or the inability to provide services to meet the complex needs of clients. Two Focus group participants reported:

The Housing Support Program will take on clients that no other services will touch with a 10-foot pole... It's a very needy demographic area that they're covering. (FG3)

Housing support take on people that nobody else wants to take on because of either medical problems, dementia or mental illness as well. They just need so much time that there was a huge gap. (FG5)

While many clients were receiving services/packages from organisations such as Department of Housing or mental health teams, medical assistance or drug and alcohol services, many other services were also required. The case managers were able to identify gaps in service provision and to close these gaps by providing services such as early intervention strategies, follow up and coordination of a variety of other services. These services were essential to prevent clients losing their tenancy.

Focus group participants commented that the HSP was different to other service providers in that: it was the ability of those working in the HSP to

be flexible with their acceptance criteria, to be able to identify additional support services, to provide a wide range of services and to coordinate services. Their perspective of the program was that this was a unique service. Acceptance into the program was also one of the main reasons why 'at risk' clients maintained their tenancy.

We've got lots of clients that have been at risk and really the only way that they've kept their tenancy is with the support of [those working in] the HSP. It's an invaluable service to us... (FG1)

Without [those working in] the HSP there would be no one to pick up the gap... (FG2)

5.3.1.2.1 Establishing collaborative partnerships

Under this theme, (Bridging the gap), all participants in the study identified the sub-themes of the importance of establishing collaborative partnerships. All client and focus group participants reported that the success of the HSP was because of the ability of the case managers to develop collaborative relationships with both service providers and clients, thereby trying to create a seamless service for the clients. Case managers found that they were often working with a fragmented set of services rather than an integrated service system to establish collaborative working relationships. All case managers were presented with the challenge of working with organisations where service delivery arrangements were inflexible and poorly coordinated yet individuals within the organisation

were willing to change their priorities for the benefit of the client. One case manager explains:

The workers that I worked with in general I find collaborative... they may have to work within a system that perhaps is a bit rigid but at least the person within them self is quite open and collaborative and do what they can within their boundaries. So you kind of got that juxtaposition, where you're working with a strict system. But the person is quite collaborative and open so that's a positive. (CM1)

From the perspective of case managers, developing and maintaining the relationship was an ongoing process. Service providers and new clients understood that this same process was necessary for each new service provider and each new client. One case manager explains:

When you get a new client they can be very enthusiastic... you have that honeymoon period where for a couple of months... a new face as well. You've got me as a new worker... "Oh great, this is a new person I can start fresh". So there is a lot of energy that can go into that..." (CM2)

Focus group participants described how the case managers in the HSP developed a positive relationship by working closely with service providers. Case managers also fostered this relationship by ensuring all communications with service providers were open, followed up and provided ongoing feedback about individual clients. One focus group participant states:

With [those working in the] HSP... a close collaboration and I found... you ring and it's a quite good response... they always keep you in the loop via correspondence or whatever. (FG4)

5.3.1.2.2 Working towards a common goal

However, the case managers were also faced with the challenge of understanding various funding sources, responsibilities and work patterns of each service. Therefore, case managers identified that in order to establish collaborative partnerships, there was a need to work towards a common goal.

Traditionally, organisations involved with providing services for the homeless have different goals to those of the HSP as a service provider's objectives may be focused towards managing a particular issue whereas the HSP's objectives focus was on prevention and ongoing management. The result was that there were many opinions regarding the type of goals for the client. Two case managers highlighted the necessity to focus on the welfare of the client when working collaboratively with other service providers: One case manager suggested that it was:

... extremely difficult to actually draw people in... Difference of opinion, I think... trying to make the issue that the main point of all of this is the welfare of the person... we need to all collectively work together for the common good of this person rather than everybody going, well, they're not doing this, or I'm going to do this. (CM3)

In order to keep relationships active and moving forward case managers needed to remain positive. This attribute was especially important when

clients failed to attain their goals. Case managers also needed to have other attributes such as being able to be encouraging and accepting when hoarding issues continued, appointments were missed, activities of daily living were neglected and social activities were shunned. Further positive attributes required by case managers included the ability to acknowledge disappointments, knowing when to be patient and when it was time to start over again. In addition, attributes such as the ability to take one day at a time, to be optimistic and to be resilient were also required

While the rhetoric was that service providers tried to work towards a common goal for the client, case managers found that government departments lacked the necessary communication channels or flexible work patterns to meet the challenges of providing services for this client group.

... Department of Health doesn't talk to Housing NSW really; even though there's a joint guarantee of service... they are all in segments, and no other segment talks to the other segment. (CM2)

It's very difficult to get people to see outside of their own little square that they work in to see... the greater good, the other opportunity that we could have if we all just put the person in the middle, of their best welfare, and let's see if we can all just be a little bit flexible about what we need to do. (CM3)

When compared with other service providers, especially government organisations, case managers found that the HSP offered the required flexibility to accommodate conflicting priorities. This flexibility provided

case managers with time to work out common goals for the client and to be persistent to ensure goals were met. Two case managers explain:

... it [the workers in the HSP] has the flexibility to continually persist with people and have the time to persist with people in a way that other types of models don't. (CM3)

The joy of this service, and this project it is quite flexible and you can really work out where the client is at as opposed to what is your agenda... Not all services have that luxury, when you're working with services it can be frustrating. (CM2)

The state of being without any form of a home is in itself one of the most traumatic events in an individual's life. The effects especially the physical and psychological consequences cannot be underestimated. The transition from being homeless to being fully housed has enabled clients to begin to rebuild a life that is valuable and meaningful for them. To understand and appreciate how an individual's identity is affected by these experiences - is to listen to stories of what it was like to live a dichotomous life between homelessness and regaining a sense of home. In order to explain the difference between these two worlds, clients in this study used a variety of storytelling and figures of speech which incorporated memories, vignettes, similes and metaphors to shape and present visual images for the listener. The client's story begins with the reasons why some of them became homeless. For one client having a disability and being taken advantage of by a loved one was the trigger:

A lot of my partners took advantage of me because they knew I had a disability. (C7)

For another client it was a series of losses that were the instigating factor. For example, loss of success related to work, loss of health, loss of his wife and finally loss of material possessions:

It was very devastating because I was out of control. All my life I was successful... I had various posts of responsibility... that was the five years when I had a breakdown and diagnosed with bipolar and that was the beginning of all this and, of course, my wife divorced me... She got everything, even the family car and, of course, I was displaced. (C2)

Another client suggests it could be just as simple as losing control over particular events:

People don't understand how difficult it is when you had control of your life and suddenly it goes out of control and it goes out of control because other people can't be told. (C3)

Knowing where they have evolved from and their particular history provided clients with a sense of discovery. In this instance, a striking image is created to explain and clarify what it was like to lose control and as a way of expressing the unpredictable nature of control. One client uses water as a concept to illustrate the unpleasant feelings associated with being homeless. Here water in the form of rain produces negative feelings of being cold, shivering or being uncertain. Whereas when water can be

controlled feelings become positive such as being dry and being able to have some control over actions and events.

I'm so pleased that I'm not – 'where am I going to sleep tonight? Is it going to rain?' Particularly when it rains - the only time I like water when it's in a glass and I can control where it goes, down me and not on me. Not when I'm homeless and shivering. (C7)

The client's story now changes from the past to the present. The concept of sickness and health becomes the comparison to imply a new beginning. Sickness was the past and health is the future. Health is about hearing messages about change, it is about being ready to change and it is having support while you undergo change.

I was sick of being sick. I was primed; I was so ready to be helped. I wanted it and I grabbed it. I was so grateful there was someone to help me. (C3)

5.3.1.2.3 Initiating proactive interventions

Case managers needed time to initiate proactive interventions for the clients. The first level was to see the client as a whole being with physical, emotional, spiritual, social and environmental needs. The second level was to acknowledge that one area e.g. environmental concern, in particular non-payment of rent, could dramatically influence another area for the client, for example, loss of tenancy. This loss may in turn affect the whole person by generating losses in other areas such as loss of self-esteem and social contact. To achieve these levels of understanding, the case

managers needed to be continually involved and persistent with the client and to address each need as it was identified.

From the perspective of case managers, the inability to initiate proactive interventions resulted in consequences for the client. One such consequence was that the client could be evicted. Once evicted the client would need to wait for many years before they could be rehoused. Another consequence of eviction was that there was an acute lack of short-term emergency accommodation with the result that the client could easily become homeless again. One case manager describes the likely consequence of non-intervention:

... if there had been somebody that could have worked with her and intervened in the earlier stages, because the trouble is that once you get evicted from housing, you can't reapply for a period of time. I think it's seven and a half years. So it has consequences, and all of the emergency accommodation, you can only stay there for three months, so there are consequences. (CM1)

One case manager depicts how those working in the HSP are becoming much more proactive in implementing interventions to support clients:

We're doing it more now... trying to be a lot more proactive. The housing support program is an example that, trying to be more proactive as opposed to other programs... If we get in early... it's better to be proactive with a client as opposed to waiting for something to happen. (CM3)

For the case managers, initiating proactive interventions is similar to the nursing process. The essential core aspect of case management is assessment. Case managers discussed how their first assessment was undertaken. Assessment included appraisal of the whole person, including their demographics, health background including how the client became homeless. Detailed histories provided case managers with information on the physical and mental health of clients as well as how clients managed their condition/s up to this point. Information gathered during assessment also provided case managers with directions covering the feasibility of recovery or maintenance for the client. These facets would later provide the basis for planning a sustainable future for clients.

We look at the person and everything to do with the person; their age; how they got into the situation in the first place; their health. They've often have undiagnosed illnesses, undiagnosed age-related illnesses or poorly managed mental health issues. We are looking at the person's history, the viability of retrieving the situation, and then sustaining it afterwards. (CM3)

From the viewpoint of the housing support professionals who refer clients to the HSP, the initiative shown by the case managers in undertaking a detailed assessment was very important. They felt confident that the clients' issues would be addressed by the HSP. Two focus group participants commented:

... undiagnosed mental health [issues]... failed tenancies, nuisance noise, harassing neighbours, the housing support program is one of

those starting points and they'll actually go through the movements of trying to get them [the clients] assessed... (FG2)

Case managers discussed how the notion of early assessment of issues/problems and exploring the reasons why clients were homeless would move quickly into developing appropriate planning strategies that could be implemented there and then with the clients. Whilst tenancy remained the main issue of concern for the clients, one case manager discussed how challenging it was to get the client to the point where they could begin planning. Another case manager stressed the importance of including education during the planning phase.

That's a challenge, getting people to the point where you can actually start to... make a bit of a plan about things for and with the client. (CM1)

... helping him and teaching him all of those things, and making sure that the place doesn't get into disarray. Helping him plan things, how to get to appointments and how are we going to go about doing that? (CM1)

The importance of proactive relationships included being an advocate for the client including establishing relationships with the client and one case manager reported this.

... what they [the clients] need is an advocate, somebody to develop a relationship with them, to help and support them, to learn what they're really like, because they're mostly people that have been very isolated and it takes a long while to really get a good picture of them,

because they're used to being quite reclusive and quite secretive.
(CM3)

Implementing and evaluating activities of daily living for clients allowed case managers to engage and interact with clients in their environment. During this phase, case managers often saw positive outcomes as the behaviour of clients slowly began to change. Implementation was more than just being concerned with the outcome of having a clean living environment in the house. The process involved working through all the necessary day-to-day living skills that would lead to independence.

You start off with small steps... it's not a cleaning up process... it's working through issues such as ensuring that they are eating properly, getting the kitchen tidy, looking at their living skills and budgeting. (CM2)

One client described how the case manager helped them with daily hygiene requirements, while at the same time taking into account their limited mobility. Another client commented on how the meals that were available from the HSP were supplemented from other agencies. Often clients placed a low priority on daily activities of living such as bathing and dressing. One case manager described how any implementation of a plan needed to address a range of living skills:

... working with the client through living skills. A lot of people who have been homeless it's not important to them to groom themselves.
(CM2)

After the implementation of any plan to improve quality of care, case managers needed to monitor quality indicators to ensure success of their plans. The main objective change that could be demonstrated for clients in the HSP was that they were in secure tenancy. Maintaining tenancy was, however, reliant on improvement in many other areas such as basic living skills. Once improvements were made in these areas clients were able to engage in higher order skills such as self-expression. The main positive outcome for clients was that they were able to change their identity from homeless to a new identity, which expressed their new life – a tenant.

5.3.1.3 Theme 3: Inclusion in the world

The third and final theme of the HSP is 'Inclusion in the World' for clients. The three main areas where inclusion in the world was exemplified were in the sub-themes: accepting the victimised client; developing clients' sense of well-being; and instilling clients' sense of home.

5.3.1.3.1 Accepting the victimised client

Being able to be part of an integrated community is a central part of inclusion. Most people struggle with wanting to be connected in the world while also being a unique person with integrity and independence. Inclusion also takes into account needs such as self-esteem and sense of belonging within relationships. For someone that is homeless or at risk of homelessness, the sense of not belonging and being excluded can make an individual unmotivated and negatively affect their sense of self-efficacy.

To be socially included in a community within a space of one's own fulfils another stage within a person's hierarchy of needs. The case managers through their work in the HSP helped the clients to become included back into the world again - accepting the victimised clients by developing clients' sense of well-being and instilling sense of home.

Underlying the thought patterns of case managers and service providers is the need to find appropriate housing for clients. This thought becomes the main priority that drives actions throughout the early stages of any interactions with the clients. Case managers, however, are constantly reminded through feedback from clients (and referral agents) that if clients are to disengage from a lifestyle of homelessness, then more is involved than the single action of simply providing adequate housing. Understanding what is required and the process involved presents three main challenges for the case manager.

The first challenge faced by case managers is to understand and appreciate that clients have often been victimised because of their lack of personal hygiene, dress and general demeanour. They have also experienced stigmatisation because of their inability to communicate adequately and have often been categorised as people who should be avoided. These experiences have resulted in clients becoming withdrawn and socially isolated.

This group have traditionally been marginalised, isolated or have had a difficult life already probably have never really got a good response from a lot of human services. This is mainly because they're often people that are ill kept or unkempt and who may not be able to articulate things very well, this is the group who often get a bad response, or a negative response, from services. (CM3)

The second challenge faced by case managers is to begin to develop a positive therapeutic relationship with clients. This is achieved by case managers providing unconditional acceptance of the client regardless of their background, state of dress and history of multiple rejections by other service providers and/or society as a whole. Acceptance of the client provides case managers with the opportunity whereby they can begin to address issues that have impacted on the client and produced their current identities for example, homeless, mentally ill and street person.

You have to accept the person for the way that they are, where they are, before you can expect them to change. (CM3)

A client reflects on a relationship built on acceptance including how this type of relationship assisted in exploring and understanding their problems.

You know you're not going to get put down or you're not going to be told to go away. If you've got a problem, even if they don't understand your problem, they will sit down and talk to you about your problem and try and help you understand that problem. (C7)

5.3.1.3.2 Developing clients' sense of well-being

The final challenge faced by case managers occurred after they have developed a therapeutic relationship and acceptance with the clients. Case managers must not only provide time for the client but also the opportunity for the client to interact with them. To achieve this, case managers implemented an open door policy.

Once case managers have achieved the goals of providing housing, then developing the client's sense of well-being became the case manager's major focus. Case managers acknowledge the type of support clients now require is not directly associated with their housing needs but rather is related to breaking the cycle that resulted in homelessness in the first place. Case managers explain how previous loss of family and friends, experiences of disadvantage and mental illness have led clients to become isolated and alone:

Our group of people tend to come from a history of being homeless and socially disadvantaged and haven't worked. Particularly people, for instance, with mental illness, they're loners... you know, they're very socially isolated. They don't have friends. They don't have families. They don't have supports. (CM3)

From the perspective of clients, loss of social contact, feelings of profound isolation and loneliness often resulted in other problems such as depression and thoughts of or actual attempts of suicide.

Loneliness, when you're on your own, can cause lots of problems. Like depression. A lot of people want to commit suicide... loneliness is the worst thing in the world. You've got to have people around you. (C7)

In the past I didn't have someone to turn to. I would just go into despair. When my wife told me that she was divorcing me and she would take the children and everything I just got so despondent that I tried to commit suicide. (C2)

To prevent social withdrawal becoming a permanent way of life, case managers needed to implement a number of interventions aimed at developing clients own sense of well-being and capacity to function in society. One intervention implemented by case managers to achieve this aim was to establish contact between clients and community day centres. Some clients because of their mental illness may struggle to cope with the stress associated with social interaction. Two case managers explained how important it is to provide not only the opportunity for interaction but also a routine and gentle support to encourage interaction.

He was chronically paranoid, which is difficult and chronically delusional. It was difficult to actually speak to him and to keep the conversation going. The clients [at day centre] have been great and they all have a chat to him. He's there when the doors open every Tuesdays and Thursdays. (CM2)

I noticed him interacting with some other clients at the day centre. He was just having a chat and interacting with people more. He was a bit of a loner before and he would sit outside with his smokes and

that would be it. Now he is talking to a lot more to people. So I guess that's a positive. (CM1)

Another intervention implemented by case managers was to encourage clients to participate in activities such as hobbies, social activities and annual festive events that are an integral part of family and community life. Several clients describe the type of activities arranged by case managers that they are now able to attend:

She's [case manager] also made sure that I'm getting involved in meeting people, like coming to the activities centre and doing painting and mixing with other people. (C1)

We go out and we have barbecues. We go out to karaoke up the club and we've been out for Melbourne Cup Day, together. (C7)

We go out on barbecues. We go out when there's plays, they [the case managers in the HSP] just come and gets us and takes us on outings. We go out to the pictures together. (C4)

5.3.1.3.3 Instilling clients' sense of home

Finding appropriate accommodation for each client was not an easy process. Some clients were fortunate to be offered longer tenancies while others needed to be placed in short term accommodation until more housing that is suitable could be found.

[The Case manager] organised the place and helped get things done. They've got me the house I'm living in now... through the housing trust. Their community housing you can only stay there for so long until you get a Housing Commission house. (C7)

Instilling a sense of home, for the clients in this study meant that clients were successfully housed and assisted into a stable tenancy of three months. Although during this time there was a complex interplay between clients, the HSP and case managers, a sense of home had begun for the clients. This process involved hearing the voices of the clients while the HSP and case managers slip silently into the background while the clients move to the foreground and begin their story of recreating a sense of home.

At first clients viewed the accommodation as simply a structure that had a particular geographical location. This was a place where they could sleep and store their few belongings. Over time and regardless of the size of the accommodation there was the realisation that their new behaviours and acquired skills meant that the lease for the accommodation could be extended beyond the initial three months. In some cases, there was the potential for more long-term arrangements to be made. The outcome for clients because of having permanency related to their accommodation was that they began to claim the space as their own.

It's just a little bedsitter but I know that it's mine and I don't have to leave it. I don't have to say, where am I going after three months? I don't have to do that. It's a lease for five years and then you can lease it again after that. (C7)

Although the accommodation has an economic value to clients, as they were required to pay the rent, clients for other reasons also valued the

accommodation. Their place was taking on the characteristics of a home. It was a place where they felt that they belonged. They could feel comfortable and they could feel safe especially at night. Their place was also a space where they could reflect their personality as they made minor modifications to suit their needs. In addition, the physical surrounds of their place offered safety and security and provided a sense of freedom without boundaries.

I can come and go as I want to. (C5)

I've got my own place. No one says okay, wake up. I'm not in an institution. I'm not in a prison. I can do as I see fit and it gives me so much freedom. (C3)

From the clients' perspective, their new found freedom did not come without rules and regulations that required adherence. Although the clients appreciated that these rules and regulations could limit their freedom, there was also the realisation that they were beginning to take on a new identity by having to adhere to these rules and regulations. This identity suggested they were now becoming a 'normal' member of the community and society.

If I want to do something here I don't have to ask permission. The only rules I have to obey are the ones that any civilised person has to obey, you know, cross the road with your green light. You know what I mean, just the normal things that a normal person should do. (C3)

Clients in this study were clear that they could not achieve a sense of home without the support of the case managers. They describe how case managers supported them to regain their independence especially with

living on their own and accepting the responsibility that this involved. Having a sense of home has enabled clients to understand and appreciate their own histories, backgrounds and how these influence the type of activities that they undertake. For some clients, experiences from childhood, related to love, friendship and home life have stayed with them through their homeless period. Clients are now able to understand the healing process that is taking place as they try to recreate the vibrancy of home life by inviting friends to their home.

Friends that I've had for several years... I've never been in a position where I could invite them to my home because I've never had my home. I've got two, three people that I call friends, yes. It's a great comfort. (C3)

The physical and emotional attachment to the home makes the home central to the developing new identity the clients are discovering. The clients now have not only a sense of home but also of place. For the client, this place reflects a new beginning, their personality and their need to belong. It also provides a way of projecting into the future and a wish to die at home.

In contrast to the services provided by other agencies, the home provided for the clients were only perceived as a house, a place that is impersonal has a hierarchical focus and one that uses technical knowledge as a means to achieve outcomes. Whereas the HSP feels, more like a home, a place of learning, developing and has security.

The clients in this study have few or no bonds with their families. In this context, the Case managers in HSP becomes '*loco parentis*' for the clients in times of trouble. The HSP was successful in terms of outcomes for clients as they have made the transition from homelessness to being fully housed. Although support is still required, clients are able to cope with independent living. The clients reported that the HSP was innovative, as it has provided a sense of social belonging based on mutual acceptance and continuous relationships.

They [the case managers in the HSP] said if you have any problems let them know because they said you're better to stay with us now because you don't have any other people to rely on. (C8)

5.4 Chapter summary

In this study varying experiences of the HSP from the perspectives of clients, case managers and housing support professional have been revealed. The clients described their experiences as being a positive one with the assistance of the supportive case managers. The housing support professionals, on the other hand, also reported that the HSP is an organisation that provided a holistic approach to caring for the clients that is different from other agencies or services provided by both non-government and government organisations.

All the case managers highlighted the need to continue the long-term supportive relationship with the clients. Although case managers acknowledged that even with this level of support, some clients would leave

the program. The ones that remained required ongoing support in the HSP or other services within the organisation.

In this study, a venue for clients to tell their story concerning the importance of the HSP and case managers in their life has been provided. Their story is also about creating a new identity, it is about change, it is about a willingness to disengage from their homeless life style and their ability to re-enter the community. By telling, their story there is a sense of movement and a sense of who they have become. They have become a person who feels part of society and the wider world again. The themes and sub-themes that emerged from the data provided a positive overarching theme of “A life-changing event” for the client, which they can, now truly state: “I now have a home”, a place to feel secured and protected. In the next chapter, the findings from the MSP participants will be presented.

CHAPTER 6: FINDINGS: THE PARTICIPANTS IN THE MSP

6.1 Introduction

In this chapter the findings of the experiences of the clients, case managers and health care professionals involved in the Maintenance Support Centre (MSP) for woman who are at risk of being homeless, will be presented.

6.2 Profile of participants with the MSP

The characteristics of the participants are presented in order to provide a background and to contextualise the study. However, as participant numbers are relatively small, description of participants are limited to avoid identification of individuals and to comply with the ethical requirements of confidentiality.

The *fifteen clients* interviewed had been involved in the MSP for at least three months. The mean age of the clients was 42 years (range = 26-68). None of the participants disclosed that they were from an Aboriginal and Torres Strait Islander background. Over half (n=9) were born in Australia and the remainder (n=6) were born overseas (Thailand, India, Central Asia, Bosnia, China, Zimbabwe). All clients resided in the City of Sydney.

The *three case managers* who worked within the MSP were female. They had three to 10 years of community work experience in the community

welfare sector and in counselling and drug and alcohol services and one to six years of experience working in the MSP.

The *three healthcare professionals* who worked within the MSP included two female and one male. Their background included two registered nurses and one medical doctor. They had between four to 20 years of experience working in community health. Further demographic data were not collected to protect the identity of the small sample of participants.

6.3 Thematic findings

Interviews were undertaken with the clients, case managers and health professionals that lasted between 30 minutes and 60 minutes. The main venue for the interview with clients (14 clients) was at the MSP in a private interview room and the remainder (one client) was interviewed in their own home. Interviews with all the case managers and health professionals were conducted at the MSP in a private office.

Quotations from the participants are indicated by the use of italics. Various irrelevant words and phrases such as *mmm* and pauses have been removed and replaced with ... This indicates words have been omitted from the transcript, however, the meaning of the passage remains intact. Participants have been identified only by the use of pseudonyms, that is, MSPC1-15 for clients, MSPCM for case managers and MSPHP for the health professionals.

6.3.1 A life-changing event: I have the power to change

Similar to clients in the HSP study, the overarching theme that emerged from the themes was also “A life-changing event”. However, in the case of the clients in the MSP study, the clients indicated that they now have “the power to change”. Prior to coming into the MSP, the clients described their life as being without prospects, unable to partake in society or having the strength to cope with life challenges. The clients in the MSP were provided with the perception of the ability to change, leading to a sense of a better future. Two clients commented:

... Now it's different with me because my life is changing since being here... I am becoming stronger... happy and healthier and stronger.
(MSPC8)

I have got different strengths from coming here. You know you are not alone anymore. (MSPC13)

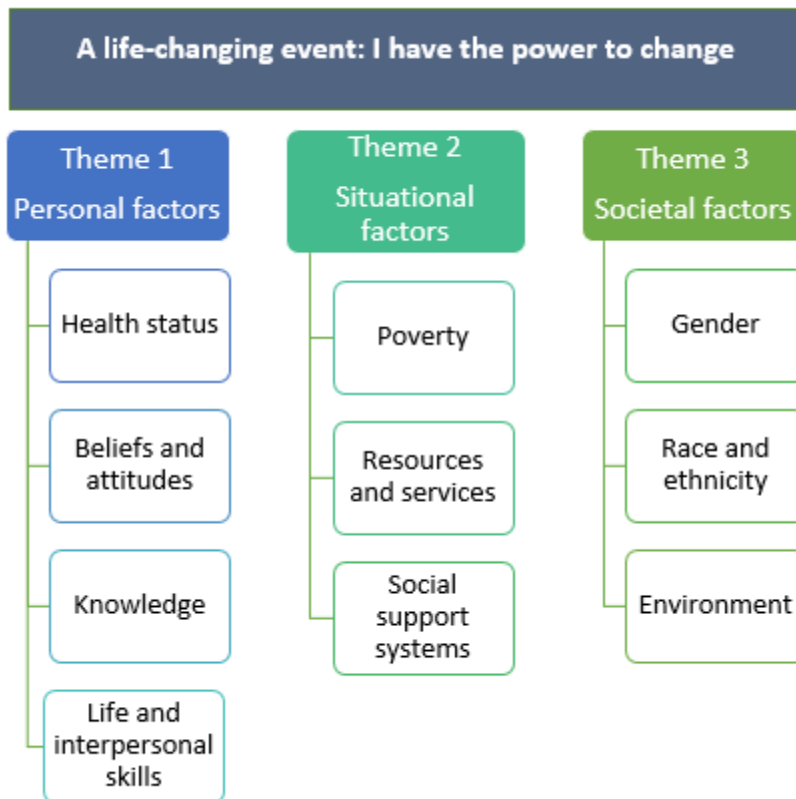


Figure 6.1 Life-changing event: I have the power to change

This life-changing event resulted from their experiences of both the enabling and constraining factors that had led to their power to change towards a better future. In this study, both enabling and constraining factors are not exclusive but worked together to influence, develop and maintain the sub-themes of a life-changing event. At times, the constraining factors outweighed the enabling factors. In this case, the clients maintained or returned to a state of instability which limited or minimised their ability to have power to change. The enabling aspects on the other hand provided the client with a sense of self, of movement, power and of a new beginning

as they now had a sense of what the future would be because of feeling empowered to change from their current situation. This over- arching theme consisted of three themes: personal, situational and societal dimensions.

6.3.1.1 Theme 1: Personal factors

The personal factors of an individual relate to the characteristics of being a person. These factors uniquely influence how an individual can negotiate challenges that occur in everyday life as well as being able to make the best of opportunities that are available. In this study, personal factors focus on the thoughts, patterns, adjustments and beliefs that are revealed over time and how these relate to the four dimensions of the life-changing event. These personal factors included four sub-themes: health status, beliefs and attitudes, knowledge, life and interpersonal skills.

6.3.1.1.1 Health status

For the clients their primary aim was to maintain tenancy. However, this aim was not always achievable because of health issues. The main health issues identified that led to homelessness were mental health problems, alcohol and other drugs dependencies and physical health limitations. Many of the clients had a co-occurring mental health disorder together with substance abuse. Two clients explain:

But my health and my situation both tumbled at the same time... it's more the anxiety... My health limits me... (MSPC1)

... I currently have depression like really, really bad and it didn't help because then I was drinking too in the past... and then drugs and stuff... (MSPC7)

The issue of having an untreated mental illness not only allowed other people to take advantage of a client's situation but also created personal traumatic chaos. As one client explained, although she survived, these difficulties constrained her ability to seek treatment and become well:

I suffer very bad bipolar [disorder]. Because of my illness I stopped my medication and I... began drinking and then... I was really badly affected and... sexually hurt and... met a couple of men and... things happened and then... marriage broke down. I ended up in refuges ... a horrible experience. Got into the wrong hands and smoking marijuana, alcohol and I ended up getting eight weeks pregnant.

I stayed with this man till I miscarried, and I nearly died. Because I was living with him on the street... he didn't even call the ambulance. But I survived, the baby gone. I never regretted it. (MSPC8)

Another aspect of being homeless and having health issues was the difficulty of getting a diagnosis and appropriate management strategies. This was compounded by denial which prevented the client from dealing with other illnesses:

I have definitely been diagnosed with depression... because of my homelessness I haven't had the chance to follow through with a lot of therapies that I have done in the past. So... to get a full proper diagnosis was quite hard. Because I think too... subconsciously I didn't want to know what was going on with me. I didn't want to face it... Now I am sure I have got diabetes... (MSPC10)

A further aspect of being homeless and living with a mental illness was the daily routine of taking essential medication. One client described the challenges:

... sometimes I get paranoid about things... what's not real. And you think that it is there, out there, and it can really get you. I can't help it. It is part of my illness. I try hard because even if you do take your medication sometimes it will still be there, so each day is like a challenge for me. (MSPC8)

An additional aspect of clients with health issues and being in unstable accommodation was the inability to connect with loved ones because of complex situations. Two clients explained:

... I can't see my mum who is the closest relative, who could help me in this situation, so it's altogether too much for me. (TC9)

I am just basically concentrating more on stabilising [my health], getting my house and stuff like that, more wanting to be with my son... (MSPC7)

6.3.1.1.2 Beliefs and attitudes

An individual's beliefs and attitudes can underpin reactions in life. One of the clients at MSP discussed her own attitude of staying in the moment as this has helped her remain positive in her life. Her attitude of getting on with life even though she might not be advancing at present enabled her to continue her journey. In contrast to this, she was critical of the negative attitudes of other clients at MSP. She reflected on how this was unhelpful and constrained other individual's views of life:

... I have got to do something... coming to The MSP is helping me stay in the moment, which is what I do when I am here. I sit out the back with these ladies and I listen to them moan and groan and I think... are you here because your attitude has soured your life or have you soured other people and that's why you are here complaining? I mean I complain too. On my own... I try to get on with it... I feel like I am running on the spot and getting nowhere but... I will keep going (MSPC2)

The same client at the MSP discussed the belief of people around her including how this attitude in society can cause distress to those in similar situations as her own:

I read something in the press the other day that all these homeless people say they are starving, has anyone noticed that most of them are fat? And I thought yes, because... the food that they can afford is not nutritious. And that's how I have put on my weight in the last little while because I have just been eating... to comfort myself... (MSPC2)

Another client illustrated the importance of the non-judgemental attitude towards the other clients as well as how their listening and ability to laugh enabled them to stay positive in their individual situations:

When you come here you are happy... it's the people that come here. They have all got different problems, they don't judge, none of the girls... I am talking about the people that come in, they don't judge anybody, if you have got a problem they listen as well. But you get a laugh. (MSPC4)

The importance of people being non-judgmental was also re-iterated by another client. She stated that the MSP is a place that no one judges women and how important this attitude is for all:

This is the only place where if a woman comes she will not be judged. Whatever age, situation... race, colour, they won't be judged. Because I have gone through racism here (Australia) sometimes in my life and it's really bad. (MSPC8)

A number of clients at the MSP discussed how their various beliefs in religions and own spirituality have enabled them to carry on in their journey of life-changing events. One client explained:

I am more spiritual than religious, I believe in like white angels and crystal balls and things like that. New age, millennium thing, but still I go to church. This has helped me. Each night I go to sleep and I pray to God... that every morning I wake up there should be a new dawn. (MSPC8)

Another woman described how her faith was tested when confronted by the other women around her and how this enabled her to use her religious beliefs to continue:

The current situation where women come and go and you don't get ... the best of women that come through... it's been trying my patience quite a bit and it's also testing my faith. I need to work through this, because I know it's a big test on my faith on how I would react to them... I am a Salvationist. A Christian. (MSPC10)

One of the other women described how her own beliefs in Buddhism helped provide more focus in her life and at present, she has the time to practice:

I am studying Buddhism right now. ... it can help me to get focused because ... I don't have very good concentration. It helps me to focus. Clear my mind... I practice regularly, because... I have more time now... I have a lot of time, and so I can spend time studying Buddhism. (MSPC12)

The need to have a belief and faith in a higher power that will enable the women to continue through the circumstances in which they find themselves was also expressed by one of the women:

God has helped me through this. I mean you can have, lots of people have faith in other things... and I admire them having faith in other things, but I wish... they had faith in the lord, but at least they have a faith in something, and that pulls them through that. (MSPC14)

The negative beliefs, fears and blame that one client summed up were dissipating slowly as a result of the support given to her at the MSP enabling her to continue getting help:

So I am going to continue and get the help and I can see what it's doing for me because a lot of my fears are leaving me slowly as I am coming here [The MSP]. A lot of times I... blamed myself for so many things. I felt bad about some of... my decisions, bad about things that I have done. (MSPC13)

The participants also reported the enabling factors that change their lives. Individuals usually believe they have some power and control to be able to manage activities in their day-to-day existence. Within this study, fundamental aspects of power and control are strength, being pragmatic, wellbeing and independence. A number of the clients discussed the concepts of lack of power and being out of control.

Once clients in this study had some control over other factors in their lives such as their health and housing, they could focus on being ready for other challenges to allow them to regain control. One client reflected on her past relationships, and her present situation and how her strength has helped her in this current distressing situation:

... since my health improved and being here [MSP] then I thought I have got to do something, this is getting out of control. I broke up with the boyfriend, I had the strength to do this... My health issues... just too much for him. And I understand that, but it broke my heart. I came home and it was like I had been robbed. He had left without sort of telling me that he was going to go. I was devastated.
(MSPC2)

Part of having strength could be resilience and perseverance built up over years of experience. Coming into the MSP had supported one client throughout this measured recovery period. She reflected on her background and hiding her emotions from others:

I am resilient. I think it's because I have gone through hell in my life that I know that at the end of the day that it makes you a stronger

person. And also because I hide a lot... emotionally. It's just always been me. If I am having a bad day with the pain in my back it's just... I still persevere with it. Coming here to [MSP] sees me through... just... take one little step at a time. (MSPC5)

Similarly, another client discusses how her strength comes from her experiences and now she has more control in her life, which in turn has given her a sense of safety and having some sense of knowing where her future lies:

My strength comes from... years of fighting... years of just... battling things that were out of my control. Now... I feel like I have got a lot more of my own control back after being here [MSP]. I definitely feel safer... Just more in control. And that I am... not just walking blindly... every footstep that I make... counts for something. (MSP10)

Having a pragmatic approach to situations allowed clients to accept their situation. Pragmatism involves strength in being able to change within a changing situation, being practical and flexible.

One client at the MSP described being able to harness her strength from the support being afforded to her and being able to compare her situation with others:

And I... admire the fact that coming to [MSP]... can chat to [case managers] and you are sitting with the women and they... are from all walks of life, and all different characters, we relate to each other. Having different things happen... And then you think oh well my life is not so bad... everyone has different problems and it's not so bad.

So you get... You get different strengths... I have got different strengths from coming here... you are not alone... (MSPC13)

Having support from the caseworkers in the MSP allowed the clients to consider changing their lives and enabled them to reflect on becoming healthier and stronger. Two clients acknowledged this:

... I don't want my life to be controlled. ...now it's different with me because my life is changing since being here... I am becoming stronger... happy and healthier and stronger. (MSPC8)

... [the caseworkers in the MSP] is a very nice, supportive place... keeps me strong. Things will improve... that's what I keep saying to myself. (MSPC9)

Another client expressed being mentally healthier and being able to have some control with her disorder after being involved in the services at MSP:

... when I first went into the refuge my OCD [Obsessive-Compulsive Disorder] was really, it was just off the chain. I just couldn't control it. My OCD has been triggered... I am a door checker and a counter. But now you know, after being helped from here [in the MSP] what always stands out for me now it's almost like I can see that... what I am doing... I am signalling to my brain, having some control... (MSPC10)

Power and control is also characterised by the amount of independence that individuals are capable of undertaking as part of their goals in moving towards a sense of future in diverse situations.

6.3.1.1.3 Knowledge

Acquisition of knowledge through self-experience, information gathering from other clients and from professionals, empowered clients towards their life-changing event. Having a lack of knowledge caused issues in health, and being able to prioritise events. One of the clients from the MSP used her own misinformed knowledge to the detriment and constraint of her own health. She described:

... actually went to the GP and... I am getting these symptoms, for depression I said I had these symptoms, feeling flat... And I wanted to be put on the medication... and so he put me on the anti-depressant, and the same with the anti-psychotic. ...I actively pursued being put on the medication. I only found out recently that the medication can cause obesity... I didn't know... the side effects which was quite dangerous I suppose. (MSPC1)

Another client followed up issues, found the GP in the MSP's was helpful, and filled in the gaps of her knowledge:

I am looking to find a psychiatrist that I can come under and talk to. And the GP here helps as well. They said I am taking enough medication to kill a horse and she didn't actually know why I was taking the quantity I was taking. So I'm being re-assessed. (MSPC14)

Other clients recounted the knowledge that they gleaned from listening to the women around them and described their various experiences:

I found it very educational talking to people, their experience... because we each come from different backgrounds and each come

from different circumstances. So it's interesting and educational to listen to other people's perspective. (MSPC15)

Knowledge given by other clients concerning the support services available was seen as factual knowledge, enabling understanding as one client posited:

It's a reality check... they tell you the truth and they tell you what's really going on... The women here. The people, the clients... they give you a good understanding of services available... and the reality of what's going on within those services. (MSPC15)

Having had experience and then being able to give that knowledge to other clients was seen as part of the positive experience of recovery for one client:

... and I am also helping other women with advice. Because sometimes if I have gone through that and if I have recovered from it I can help them recover from it. (MSPC11)

Another client also disclosed that being able to draw on experiences and her own education has helped others in the MSP on the way to recovery:

Sometimes... they [clients]... at [the refuge] they say 'do you work here?' You sound like you work here, like the new ones. I go no... That's the way I speak. They think I sound like a staff member... a counsellor... it's just years of educating myself and just a lot of experience... that's what [The MSP] is about as well... passing it [knowledge] on and helping others recover. Not keeping it... to themselves... we have been helped then help others. (MSPC14)

Having a role model and accepting that we continue to improve our knowledge and learn about life then passing this knowledge onto others has enabled the following client to remain optimistic about the future:

I know the steps that I need to take to finally get there and I think everyone still has those steps, because we are all learning till the end, until the day we have gone so... there are always new things coming up. And I didn't think my mother would turn around and say to me that she is still learning... new things... learning to become a grandmother and... passing the baton on to someone else.
(MSPC10)

Knowledge also included an understanding of self. This understanding of the self, involves the meanings that we attribute to making sense of the social world and how we act within it. Individuals engage in social interactions and processes, which have personal meaning within society. Individual personal meaning involves preservation and maintenance of a sense of self. Within this study, key aspects of an understanding of the self are maintaining by a sense of self-identity, self-esteem, self-confidence thereby re-establishing of a sense of self.

Having a personal and social sense of self-identity within a neighbourhood and the wider community means that an individual must have a secure home. Being cognisant of how to build up self-esteem and confidence is part of the ability to understand one's own capabilities and self-identity. In the MSP, there were a number of groups that targeted self-esteem issues, self-confidence and life goals. Increased self-efficacy contributed to positive

choices about pathways in life, in the individual. One of the clients acknowledged that taking part in group activities and conversing with other individuals who are not using alcohol or other substances helped with her development of self-confidence:

I am slowly building up my self-esteem... by doing groups and stuff like that. [Having a social group] will build up confidence. ... it will build up that you know, you can sit down and have a normal conversation with somebody that... doesn't drink and doesn't take drugs... It's kind of like a little bit too hard to find somebody that doesn't drink and doesn't take drugs. But it's... building up confidence for me. (MSPC5)

Similarly, two other clients described how the groups help with their own self-growth and development:

I come here to do the women life course group... this was really good... we talked about self-confidence and... has helped with mine. (MSPC10)

I am in the program tomorrow afternoon they have got the personal development thing. That's excellent... (MSPC4)

Another client recounted identifying abilities that help with self-confidence and the challenges of maintaining hope about the future by being involved in supportive group activities in the MSP:

I went to the first support group. To try and build people's confidences... and doing the creative writing... it's showed me that I have a gift I suppose or an ability to write well. I found out that I am good at creative writing.

... this is fundamental to my growth so to speak because I have to have some sort of hope to hang onto. Especially in this sort of situation. But my future is my hope. And without hope it's... very, very hard to exist especially... being homeless. (MSPC15)

Resonating with the above client's experience is another woman who finds that the activities that are available at MSP helped her to escape. This exploration of her own individual talents, in turn helped her in the improvement of her own self-esteem and feedback from others was helpful:

Coming here I could sort of escape... like doing things like making jewellery or... painting, I would just escape into my own little world and... even some of the pieces that I do and people, being able to make people smile and love what you do, love your work and stuff... it helps your self-esteem... (MSPC10)

Having an understanding of self, involved being prepared to confront fears and uncertainty while undertaking difficult changes and re-establishing a future identity / life. One client from MSP described the dilemma of thinking about her children, how she commenced another journey of change without education and other necessities:

I think one of my fears of letting go of my situation and my marriage was in case my children didn't know where to find me. They know [who] I am by this [Refuge]. I was already so... affected by the fact that where are you going to start... Where do you start if you want to start on your own? Where do you start when you have got nothing, not even a good education behind you? (MSPC13)

This same client also commented on the future and how the caseworkers in MSP had encouraged her confidence and that this had played an important part in being able to have a sense of future:

Yes, I think I am living now, I feel like I am getting there because of [the caseworkers in the MSP] I am getting more confident about the future. I am not so fearful. I was fearful about a lot of things.
(MSPC13)

Another client understood and acknowledged that change was part of her life and being part of the MSP allowed her to re-ignite her confidence over time, allowing her to be part of the future:

You know, everything changes, everything happens for a reason. And people can change as well. I know what I want and it's just... takes me a bit of time and confidence to get there but... if you hit a brick wall well you bounce back.

... so this time round and with support from [the caseworkers in the MSP] ... I have much more self-confidence and slowly building up my own self... knowing I can achieve things. (MSPC6)

Accepting how to act, appear and improve self-image is part of re-establishing the self for the future. One client believed this is important and tried to take advice from staff at MSP, even though impeded by her own financial situation and lack of confidence:

... I don't pay too much attention on my appearance to be honest. I know for my future you have to look after yourself, your, image... But I just, don't pay it too much attention. ... I just don't have an interest, but I think it is important. Especially to the industry, like an office,

you have to... be aware of your appearance, that's very important, I have to improve my appearance. [The Case manager] gave me this advice before I go for my job and I try to take their advice. But it is hard when you haven't got the money or confidence, that's part of the reasons. (MSPC12)

Another woman expressed her need to re-establish herself with employment, which would help with her sense of a future life:

I want to try to re-establish myself. But it hasn't been successful. But my future is to re-establish myself again in, have a job. So I mean... you have... more of a go in society when you get work. You then meet more people and develop skill. (MSPC3)

6.3.1.1.4 Life and interpersonal skills

There were a number of skills that were incorporated into the everyday lives of the clients to cope with everyday existence. At times support was given to the clients for self-management, life skills and interpersonal skills. The clients at the MSP also had a lack of direction and lack of being taught skills from a family perspective. One client reflected on her background and lack of this support:

I was brought up in orphanages so we weren't really taught much. But then I taught myself everything as I had a family... because you have to, they want to know from you... so I taught myself along the way. But my thing was I did put my life on hold for my children... not having a mother myself... it was important. (MSPC1)

Other interpersonal skills that the woman discussed included being involved, remaining positive, coping and being strong, self-reliance, taking

ownership of emotions, learning from role models and being able to compare their own situation with those of others. One client from the MSP described trying to be involved in what was happening around her. Being in the present was seen as strength for her, together with her own internal positivity, which she did not understand:

So they see I give everything a go. So when I say I can't do something I really can't. I still try. One thing... no matter what happens... there is this... positive thing inside me.

It's weird to understand. I can't understand it. It keeps me going. But it's not one I force on me either, it's just one that's sitting there. I was this far from being on the street... I don't know what it is. I still feel positive. (MSPC1)

Resonating with the previous client, other clients also discussed being positive and accepting what is happening in the present:

Just get away from there [refuge] and hope that something is going to happen and try to stay positive. And accept what's happening for now... this is a godsend coming here [the MSP]. (MSPC2)

... one step at a time. And... just belief and positivity I think. (MSPC10)

Another client discussed the importance of coping and appearances. She described how this appearance of being confident enabled her to appear strong, not weak, which was important for survival:

I think that's more important for me to cope. People have always said 'oh you appear so confident'. I said... well... the active word there is

'appear'. Because I don't want to look vulnerable, I don't want to look... weak. (MSPC2)

Another client stated that she did not have anyone else in her life, therefore she needed to be self-reliant:

Because there is really nobody in my life that can step in and take care of me... So I have to... (MSPC3)

One client discussed how her background and examples from her mother prepared her for her present situation where strength is necessary:

... seeing the strength in my mother even though she was the one I was battling against, but at the same time she also was a very strong woman. And she did it all on her own and she didn't... get handouts and that was a very good example... to see that you can do it on your own and it doesn't really matter what others say. (MSPC10)

The same client also attributed her coping and growing through the experience when becoming a mother herself:

Oh definitely, it's hit home. ... When I had my son I just grew up overnight. They say that you can't, but I did with him. As soon as I had him there was just something that clicked in me that... I grew up. (MSPC10)

Gaining education from admired public figures and role models also helped with strengthening interpersonal skills. One client described how taking ownership of her energy and her emotion resonated with her as well as remaining strong when facing her reality:

And I love what Oprah said... even though it wasn't from her it's from a doctor that suffered from a stroke, 'take ownership of the energy you bring into a room... feel the energies around us' maybe that's what we gravitate to... I am creating my own destiny and it's not easy. ... I know what my reality is and I know what the reality of the outside world is and what I need to do... It's still tough. (MSPC10)

Another client attributed her ability to be strong based on her father's teaching and how feeling his presence supported her:

... my dad wouldn't want me to... He has taught me how to... just keep going and give it my best... until the time comes when you can't.... I feel his presence and he is helping me (MSPC11)

This same client also compared her situation with other woman at the MSP, who were in dire situations. This made her resolute about being able to overcome her own difficulties:

... being here (at the MSP), I mean... some of the stories here... I think oh god... I always keep that confidential but...here I am, I think my troubles... small compared to what they are... what am I complaining about. They can overcome that then I can overcome this. It shouldn't be too difficult, if they can overcome that. (MSPC11)

The same client also reflected on being able to leave a situation that was unhealthy, having the strength to make a difficult decision and then to start all over again:

.... I just don't want to be a part of a life where I am treated with no respect. I mean I gave it my best and then I can't give anymore. I had to remove myself from that situation. It's not healthy for me. That was a strong thing to do. It was a hard decision. Yeah. It's just I feel like I am going the long way around to get to, now I just feel like I have got to start all over again. I have worked so hard. (MSPC11)

Other people having control over the client's life also had a negative effect on the clients. This came from a number of various past relationships that affected the women involved. Two clients expressed:

She didn't treat me properly the way... she did when we were friends. This time she was in control and manipulative and demanding and rude. And that is not nice. So to be honest I just battled depression, from this... (MSPC4)

I have been divorced from the man for four years now. So I really want to just do my own thing. But he is a controller. And he is controlling all the women around him, including my mother. (MSPC14)

Some of the clients in the study at MSP became empowered after years of abuse and commenced taking back control from the perpetrators of abuse. The perpetrator controlled the client by using physical and financial abuse as well as using her to take on his own carer responsibilities. This client left the relationship over time with the support from of the caseworkers from the MSP as she expressed:

And he did some abuse, some sort of abuse, like controlling and hitting me... and he used me like an ATM machine, to look after his 12 year old daughter. So after being here [in the MSP] and [receiving] help from [case manager] ... I left him, he didn't left me, I left him. (MSPC8)

Another client described the need to break the cycle of control by others around her, by breaking a cycle of abuse. Having drawn support from the caseworkers in the MSP, she was able to have some control, independence and pride in her actions. She was now looking towards the future that included her son's future:

So I wanted to break that cycle. So I am breaking it. After being here [at the MSP] and thinking about my own independence... I want my son to break the cycle but that's up to him. He knows what I feel about it. And I think I am the only one that's broken it, so I feel very proud of myself...because no one else in the family has. Everyone is in the same cycle, the past and even now. So, hopefully my son will follow my lead and break that cycle so that when he does get into ... a relationship... I would do my best to put a stop to it if I ever found, if he does do that [abusing others]. (MSPC11)

Two clients discussed other communication and interpersonal skills that could be practised. These could support and enable them to continue towards their life-changing experiences:

I have social anxiety and... I have to put more energy or more time to practice talking rather than rely on the medication. Practice like talking to you at this interview. (MSPC12)

... As I am getting used to be around people... without [the caseworkers in the MSP] I would never be in the situation where I can come and have a gathering with so many women with all different type of situations. Or even seeing you... (MSPC13)

6.3.1.2 Theme 2: Situational factors

Situational factors refer to the context in which the individual find themselves, the resources and services available to them including their social networks. The situation on a day-to-day basis that the individuals find themselves in has important ramifications for being able to consider life changes. People who are homeless or at risk of being homeless deal constantly with poverty, therefore, being able to have accessibility to resources and services as well as access to social support systems is essential. These above aspects all impinged on the ability to continue with life changes and sense of future for the clients. For someone that is homeless or at risk of homelessness the sense of not belonging and being excluded can make an individual unmotivated and negatively affect their sense of self-efficacy.

To be socially included in a community within a space of one's own fulfils another stage within a person's hierarchy of needs. Their experiences of lack of personal relationships and feelings of disconnection from the community changed for the clients after participating in the MSP. Being engaged in the MSP enabled the clients to feel part of society again, and encouraged them to become involved in the world around them. Key

aspects of inclusion in the world are relationships based on acceptance, connecting with others, creating a sense of home/community. The situational factors included three sub-themes: poverty, resources and services, and social support system.

6.3.1.2.1 Poverty

For the clients the context of their life revolved around their personal grim situations. The clients lived a day-to-day existence, which impacted on their being able to move forward and plan their future. These factors influenced how they related to the world and what was important at that particular time. Other issues included financial management and living on a pension. The background of some clients who had lived in various circumstances still did not prepare the clients for the situation in which they found themselves. One client reflected:

I have seen a bit of life travelling with the circus and stuff... but not this kind of thing you know. This is real poverty. ...I have known I am living on poverty level on the pension for a few years. You know, there is not a lot of money and I have been lucky to find accommodation that was cheap. (MSPC2)

One woman recounted her inability to plan because of insecurity of accommodation. This day-to-day existence of uncertainty, instability and being a witness to injustice together with poverty constrained her ability to be able to have a sense of future through a life-changing event.

I am taking it... a day or a week at a time, so very short term stuff... because I can't sort of plan ahead because I don't know where I am going to be. Like next week I don't know if I will be sleeping in a car or if I will be on the streets or... When I came here [The MSP] I was living in a [Refuge]... I had seen a lot of women kicked out or mistreated... I had seen the injustices happen there. So the accommodation there in itself was not stable. (MSPC15)

Another client related her homeless situation and being financially bankrupt. During this difficult time, she described how important the MSP was in giving various types of support, which enabled her to continue:

... now I am homeless, oh well, I don't know whether we consider being bankrupt a privilege but definitely homeless... because I lost everything they [The MSP] give me moral support, emotional support and always... every possible ways that we need they will be there... we really need help in these situations and conditions... much needed in the life of the homeless. (MSPC3)

Similarly, another woman described having a relief from the reality of being homeless and the people living on the street, which was far from her previous reality:

... it's a relief coming here. A relief from reality, but a real reality bite as well by seeing people that are, call them 'streeties' I suppose. And I have never known people like that before. (MSPC2)

6.3.1.2.2 Resources and services

A number of resources and services contributed to enabling individuals in their situations to consider that they were supported in their life changes

and allowing them to consider a sense of future existence. This included health resources, holistic care and general local community services. Health resources that were available helped the clients to negotiate and face health challenges. The case managers organised the health care and follow-up for the women. One woman described how reassessment is necessary and therefore, comes to the MSP for this health support:

I come here on a regular basis to see my case manager for reassessment of how I am going... (MSPC8)

... seeing [the Case manager] ... improves my health (MSPC11)

Another client described the importance of being able to have access to a health professional and health checks that she had not been able to have for a number of years:

I saw the lady doctor who deals with the ladies here all the time. So I had pap smears, first time in ten years. She also got me to see... a lady counsellor, like social worker... she... deals with homelessness and my emphysema... So you get all the right information for you medically from the doctor... so lovely to talk to and listens to everything. (MSPC1)

Another client concurred how being with a female doctor is important to her:

I saw the doctor and she is wonderful... it's nice to see [woman doctor] for personal reasons... she is here every fortnight on a Tuesday... I feel comfortable with her. She is very, very nice. (MSPC11)

Two clients described how the doctor has helped with referrals that have enabled them to become involved in on-going counselling:

... doctor referred me to a counsellor... sort of knows more like about everything that was going on... just talking to someone like that... so you can lay everything out and she is really a big help (MSPC7)

I had psychologist that the doctor, the GP sent me to... it was helpful... he specialises in dealing with homeless people. And he listens a lot... Doesn't give much advice, but he listens. (MSPC9)

One of the health professionals at the MSP discussed the problem of not enough provision of services and the negative impact this had on one particular client:

... she is someone who would have fallen between the cracks because the mental health service wouldn't have seen her. (MSPHP)

Access to community mental health services was also an ongoing issue for clients with mental health diagnoses as stated by another health professional at the MSP:

... being more of an issue is the difficulty with access to the community mental health services, the area mental health services and I see that as being a gap that's been created... (MSPHP)

For one client being able to have medications stabilised by seeing a health professional in the MSP contributed to being both physically and mentally healthier than previously:

I have a thyroid condition... and I should stop smoking... my mental health suffers... but I have had more success with the health than

anything else, getting medication stabilised here at [the MSP].
(MSPC2)

The case managers at the MSP were seen as being very caring, supportive, trustworthy and non-judgemental. The case managers enabled the clients to keep calm, undertake health assessments and helped with confidence building. A number of clients acknowledged these important attributes:

... her [case manager's] nature she is very calm... understanding, kind... everybody here seem to have the proper approach. And they keep me calm too... (MSPC3)

I have got my back, with the disc, that's why I have got to see the neuro. [The Case manager] has been so supportive about me losing weight and telling me about doing hydrotherapy that's available here... (MSPC5)

... you build up confidence and you build up trust with [the case manager] ... she also helped with getting the counsellor I'm seeing now. And was not judgemental... (MSPC5)

Having resources available in one centre with support of various health professionals was also seen as essential. Two clients expressed:

... I am seeing the psychologist here and the doctor here. I am quite happy with that, it's brilliant. And seeing it's all in the one service you just, you can't ask for anything more. All my support is just in one building and it's great. (MSPC6)

I have been seen by the mental health team... not by choice... now I'm seeing a counsellor... There are lots of different services available

here such as a counsellor or a health... nurse and it is central.
(MSPC14)

Services enabled the clients to enjoy nutritionally regular; healthy meals. The meals that were given by the volunteers to the clients at The MSP were praised by the clients. Three clients commented positively on the healthy quality, free food available:

... they are just wonderful here... even the volunteers that come in to do the cooking. Like down in [the Refuge] ... I know they do their best. But we get frozen meals for dinner every night. To come here and get a decent meal at lunch it's just a god send. (MSPC4)

They make sure it's a healthy food, not very fried and all. It's healthy, lots of carbs and proteins and things like that. I would say it's better than restaurant class meals. It's healthy and cooked with love. Homely. (MSPC8)

There was free meals here... they come from Harvest... there is not a lot of places that you can go to that have that. And it was great to have... a good lunch, healthy breakfast and lunch. And be able to sit and... eat like a human with other people. (MSPC10)

6.3.1.2.3 Social support systems

The majority of the clients at the MSP were living on their own without any social support from family, neighbours or friends. Their personal support systems and relationships were often strained, traumatic or lacking. A number of women at the MSP related issues of abandonment and trauma. Past family relationships had broken down, constraining their development towards a life-changing event and future relationships. Children were

considered as being part of a supportive family relationship, although this is not always the case. One client discussed a lack of support and receiving abuse from her daughter:

I just thought my family would have been a bit more support... But she [my daughter] drinks and becomes violent so that's out... because she is like six foot and quite a big girl and would beat me up really bad when she was drunk. (MSPC1)

Another client described being alone with no available family relationship:

I was adopted... no ties with my real family or my adopted one... (MSPC10)

Past, personal, abusive relationships had a debilitating effect and caused feelings of abandonment, rejection and distress. One client explained her background:

There is a history of abuse in my family. I left when I was... 18 or 19... because the abuse was physical... there is a lot of things that I don't remember... which obviously indicates trauma. A lot of trauma... my parents... they don't want to know about my disability, they don't accept that I have a disability. They have literally abandoned me. So that's their position. (MSPC15)

This same client continued and described how her main personal support is her cousin:

My cousin... she has helped me... So she has been my main support, which has been good... she is my main support in a lot of different areas, both physical and spiritual. (MSPC15)

For clients at MSP, the importance of being accepted by all staff and other clients is similarly re-iterated:

... I seem to be readily accepted here and most of the ladies and the staff have accepted me... that is important. (MSPC2)

... if I become too panicked, uptight, she [the Case manager] will say one thing at a time, one thing at a time... they genuinely care for you, making me slow down and realise what I'm doing. (MSPC3)

One client described how all clients are accepted although if there are behavioural issues, this is not tolerated:

... So no favouritism and no racism here. Violence against other people here is not accepted. And I have seen that if some... girls are being violent towards other girls they are told to leave straight away (MSPC8)

Once case managers have achieved the goals of providing housing, establishing a therapeutic relationship and supporting clients as they achieve the basic skills required for community living, the focus of their work changes. Case managers acknowledged the type of support clients now required was not directly associated with their housing needs but rather related to breaking the cycle that resulted in homelessness in the first place. Case managers explained how previous loss of family and friends, experiences of disadvantage and mental illness had led to clients becoming isolated and alone:

Our group of people tend to come from a history of being homeless and social disadvantage and haven't worked. Particularly people, for instance, with mental illness, they're loners... you know, they're very

socially isolated. They don't have friends. They don't have families. They don't have supports. (MSPCM)

They probably haven't been in the work arena where you've been around people and developed good social skills, developed ways to solve problems. (MSPCM)

Lack of social connection and loneliness also can be from experiences and past relationships. One client acknowledged that being at MSP where she connected with other clients was important to her:

... sometimes I get, I feel lonely. So I come here [to the MSP] to not feel lonely. ... I have made some friendships and so I try and just catch up on our social life. Which is good. I didn't really have a social life before. Because my life really revolved around my son for years. Because of his health, the asthma... (MSPC11)

... so many are just so lonely. So it's good to come here and ...not feel that lonely feelings... It's good (MSPC11)

The health professionals and case managers at MSP also saw the benefits for the clients of developing relationships with not only other clients but with staff and health providers. Two health professionals described:

And the fact that they do have... reliable and consistent relationships with health providers... then this is part of their recovery... (MSPHP)

There are an incredible range of things for women to take advantage of. Food, shelter, companionship and health; But it is the companionship that really is central... (MSPCM)

At the MSP, various groups were available for the women to be able to feel included with other women and part of the MSP community. The

volunteers at MSP ran these groups. They included art groups, craft and sewing groups, music and singing groups. One client recounted coming back to MSP to be involved in the singing group and she indicated how important this was to her:

I do a singing group on Tuesdays. That's fantastic. From [the MSP] we go down to the [recording studio] and record which something I have wanted to do... also having others interested in the same thing I am... the volunteers help organise this which is fantastic (MSPC2)

Other clients' described the various activities available at the MSP and illustrated how these bring them together in friendship and social groups:

And there is always something going on ... the activities that you can participate in and join others. (MSPC1)

I do come here ... just to see friends. And the activities... I enjoy the jewellery and beading and sewing... (MSPC3)

I have got friends here and also the workers. I like doing art... I never knew that... I could paint... (MSPC10)

I have participation issues... but the classes at [MSP] help this...it is a social thing... I try to cope... (MSPC12)

Inclusion in world also meant being able to participate in a community, to feel connected with others in a sense of belonging to a group. Feeling connected as part of a community has positive effects for a number of clients in this study. Being involved in groups, participating in dialogue, verbal persuasion with others in a safe, supportive environment helped with self-efficacy and positive goal setting. This was particularly seen in the

stories from the clients at the MSP. Two clients commented about the support of this community and what this meant to them:

The main benefit of being here [the MSP] is the feeling of community, the community and the support. And often times if I am upset I won't talk to the other women about it, I will talk to staff...
(MSPC2)

Maybe I am so used to this area and I feel... like [the MSP] this is my friend, this is my family, because this is part of my establishment here. (MSPC3)

Establishing and feeling part of the community was important, one client reflected that the MSP has made her feel comfortable and welcome:

I notice all the women know one another and I am getting to know them too. And when they know you are new the other ladies... make you feel comfortable. Make you feel part of the community and make a point of saying hello because they know you are new.
(MSPC1)

Another client described the importance of being treated appropriately by others as if they were in their own home. This allowed them to feel that they were supported within the community:

There is a big sense of community here [at the MSP] and we are treated as humans... like we would in our own home or something. The way we share and making everyone definitely feel part of a community. I guess it is knowing the people that come here... you tend to see the same faces a lot so that definitely helps. And just knowing that... the support is here... it just... helps out... in that part definitely. (MSPC10)

This same client expressed her delight in having relationships that have now built up whilst being part of this community:

Because I get that sense of community, I like the relationships that I have built up. (MSPC10)

Being part of the community also involved checking that the clients were well when clients had not been able to attend. One client commented:

I am a regular here and when I don't come they say oh, where have you been? Are you alright sort of thing. So it's really lovely. And for the... last year I was here pretty much here every day that they were open. (MSPC2)

There were also challenges in being part of any community. People who for various reasons cannot participate positively in the community or are not interested in being part of this positive group could cause disharmony in the community. Two clients acknowledged this:

... with it [MSP] I have seen the positives for me and the negatives... I meet somebody... she just seemed angry. And then I started to realise oh wow, that's what I used to be. That's what it was like before, when I was with the man, I just used to be angry and I never knew his problem. But I found out later that it was through drugs. But... she was just angry... then I just ignored and I didn't take much notice. Otherwise its good because you come here and the other women will be talking to me, asking me, how are you? What are you doing today? Or do you want to come and join us? (MSPC13)

In contrast to the majority of the clients attending the MSP, one client acknowledged the sense of community but did not want to associate with some of the clients that were part of the MSP:

... there is a community of different types but I didn't make any friends there because there is a lot of weird people and it could be dangerous even to make friends with them. There are lots of gamblers and people with drug problems... but... I do have my friend from the refuge. She still is my friend. (MSPC9)

Opportunities to have provided some relief from their reality have contributed to the clients wanting to be part of the community at the MSP. This has improved the well-being of clients as two reflected:

... my outlook on life has definitely improved. I am not so... dark and depressed... I am getting out there. [The MSP] was a very big part of me getting out every day. Coming somewhere, getting dressed, getting out of the house. That was a very big part... of me taking those steps... now it's just like normal. I just get out every day (MSPC10)

... at the refuge they are always... at you... get up and out... it's more depressing when I... was sick and I literally had to be in bed... Even though I took my medications to not feel depressed I still found it quite depressing. So... I know that I need to get out, to go to [the MSP] to exhaust myself physically and you know maintain my energy... it gives me more of a positive exhaustion than... a negative one. (MSPC1)

Another client acknowledged that as well as being a support network, there is motivation to attend the MSP to see the case managers:

We all need a support network, which is here [MSP]. It can come from one of these guys [the case managers] ... that's what I mean there is days when I don't want to get out of bed, then you come up here and tell them, I am feeling like this. You can hide it to a point. (MSPC5)

One client discussed the need to give other women the chance to be at the MSP therefore, she limits her attendance:

So I also try to think of my day that is not every day for [the MSP] because there are other women that need the chance too. So I... will choose an alternative place and when I come and it's full I say well they definitely needed it and I go back. (MSPC13)

6.3.1.3 Theme 3: Societal factors

Societal factors refer to the aspects of the individual, which constrained or enabled their capacity to interact with others, within social backgrounds and the physical surroundings. Being able to be part of an integrated community is a central part of inclusion. Most people struggle with wanting to be connected in the world while also being a unique person with integrity, independence and awareness of own background. Inclusion also takes into account needs such as sense of belonging within their surroundings. These societal factors included the influence of three sub-themes: gender, race, ethnicity and the environment.

6.3.1.3.1 Gender

The effect of gender on the capacity to enable or constrain individuals to move to a life-changing event and therefore a sense of future included socially constructed roles assigned to women. These were based on cultural beliefs and values as well as social structures such as work and family roles. For many of the female clients in this study, their roles were ill defined and were dependent on their background. This also included their ability to see where they were at present and how this could change in the future. One client described not being able to have any educational and employment opportunities because of her gender and early life period:

... I would have been the type of person that wouldn't have minded going into the air force or army but women just... weren't allowed to then... Didn't have that opportunity... (MSPC1)

Another woman commented on being a mother and because of her lack of mothering decided she needed to concentrate on this career as a mother, not thinking of other plans, although not sure of the family process:

... my thing was I did put my life on hold for my children. See not having a mother myself that it was important... You were there for them... And I didn't know how a family worked. (MSPC1)

Many clients at the MSP, had a background of inequality which included lack of support from their families, issues of abuse, such as, being affected by domestic violence. They also experienced a lack of economic security and they were financially dependent. One client indicated that being a single

mother who had experienced domestic violence and the associated trauma, constrained her ability to cope:

... my emotional condition could be better. But then I have a pressure of being a single mum and plus... I still have the trauma from domestic violence... (MSPC9)

Another client described the abuse suffered from her adoptive mother and described how she covered up the abuse:

I am an adopted child and my mother was very abusive and she just died two years ago... she managed to tell everybody that I had a mental illness... to cover up her abuse. (MSPC2)

Repetitive, abusive relationships also constrained another client from being able to be her own person and kept her within her controlling partner's life:

... I then got married for the second time and had a problem of the man doing a similar thing of just abusing me and just aggressiveness. ... when you have been through it once, I couldn't make out the difference between one to another. And because he was so controlling I didn't have chances of going out, of venturing out much. So I stayed within his circle of friends and lifestyle. (MSPC13)

The same client identified that in her past life overseas the role of the woman in a relationship was to be submissive and compliant in order to support the needs of the male partner:

I... just accepted... I just stayed at home... doing traditional wife things... I was always doing the things at home, doing what he wanted... because I was used to that in Africa where you have to do what the men wants and not what you wanted... (MSPC13)

This client also was constrained by a lack of understanding about how to get protection in Australia as she came here as a refugee, not knowing how to break the circle of abuse she was in.

I didn't have my permanent stay here in Australia and I didn't know a lot of things about the laws in the country that even though I didn't have my stay I could have... have reported this [abuse] to someone ... But this type of men actually keep you in their circle so tightly that... I never thought about... around the outside circle. (MSPC13)

Eventually the same client decided that her children were more important than her safety and received help, which then enabled her to consider this event as life-changing:

But when I could not take it anymore and when [he] push me then I thought from here I am going straight to the police. And I walked straight to the police thinking... just go and tell somebody because my heart was beating and I was so fearful on that day he is going to do something to me... I am thinking about my children, I never stopped to think about myself, it didn't bother me. So when I went to the police they straight away said no, you take out an AVO on him and they asked me... they were very good. They were very helpful... from then my life changed. (MSPC13)

Having had difficult surgery because of sexual abuse by her husband, one client pondered her ability to endure pending major surgery, although she has survived her past abuse:

My health has deteriorated because of him... I had bowel surgery last year which was needed due to continual rape in the marriage. On top

of this I have had to have open heart surgery because I have got an aneurism and a hole in my heart. I am not sure how this will go... at least I survived him... (MSPC14)

A number of clients discussed losses that occurred in their past lives as puzzling. These included loss of relationships and loss of finances. One client described her previous life and the present life:

This... is a whole new life, like at my age, I am 65... So I never thought I would be in this, homeless sort of situation. ... my marriage blew up and then I met someone else and then he passed away... no money or back up... I have been coming here [the MSP] since I came to Sydney. I didn't know it existed before... My other life, that's gone. (MSPC4)

This same client commented on her lack of possessions and now needed to commence her life again:

I just bought some clothes and a suitcase and a canvas bag thing and that was it. I left everything. So I am starting off from scratch again. 65 and starting off from scratch. (MSPC4)

Another client described her challenging background and her history of being the carer in the family because of her gender that also extended into her married life. Although having gone through this difficult time, she expressed her capacity to endure:

I grew up with a mother with a brain injury and mood swings... I was the only girl... and so I learnt to live with that and looked after things... Then I married a man who had bipolar. We had a spina bifida child. With spinal surgery at 12 weeks of age, then open heart

surgery at two and then a major car accident six weeks after that. I am now here and I am still hanging in there. (MSPC14)

6.3.1.3.2 Race and ethnicity

Individuals who come from culturally and linguistically diverse (CALD) backgrounds can suffer from discrimination, racism and social exclusion. They can be doubly disadvantaged if also homeless or at risk of homelessness. Having this disadvantage impacted upon the capacity of the individual to work towards a life-changing event and sense of future. There were a number of clients in this study that came from CALD communities. Cultural factors have an impact on the presence of stigma that can exclude people with mental illness from being accepted by their communities and families, thereby constraining their support. Conversely, the understanding by the client's case manager and education concerning mental illness and medication enabled the client to consider treatment. One of the clients explains this social exclusion:

In [an Asian country] where I come from my parents don't understand this illness because we don't understand mental illness in [an Asian country] and especially we don't have bipolar there, but [the case manager] understands that. So my mum doesn't know that's why I was sleeping around with so many men wasn't me normally... I wasn't aware that I was putting myself in vulnerable situation but [The MSP] told me that what I was doing was not good because I wasn't on my medication. But now I am on my medication. (MSPC8)

For one of the clients who was a refugee, discrimination began within her community prior to her coming to Australia as reflected:

I came in as a refugee for the reasons of the political situation in [an African country] And I think sometimes I look at my situation and I think there is difficulties from the beginning... my granny gave up my mum because she couldn't have this child who was lighter in the community because people were always mocking. (MSPC13)

Another client stated that racism has negatively impacted on her:

... coming from [a Pacific Island] I have gone through racism here sometimes in my life and it's really bad. (MSPC4)

Having a background of being settled in one country, losing your supports and resources and then coming to another country can be very difficult on top of having a mental illness and a CALD background. One woman recounted her situation:

After my parents died I ran into some personal problems and I lost everything. I did end up as a bankrupt and homeless because... the powerful group took all my properties. So I came back to Australia. This is my fifth return from [an Asian country] and I tried to re-establish myself. (MSPC3)

This same person also combatted her own physical and mental illnesses, which was difficult in her homeless situation:

... health is very, most important but I just found out about this thyroid... And I also am depressed... I came from a good life in [Asia] so very hard to settle down... being homeless doesn't help. (MSPC3)

The treatment of women differs in many countries of the world. Women from various CALD backgrounds can be viewed only in certain roles and having only certain responsibilities. One client disclosed the problems within her marriage to a man from a CALD background that had respect for male heirs only. This constrained her ability to have respect from her husband's family, being seen as the wife who was only the caretaker:

My son's other relatives... They love him so much... being a male, [an Arabic background] ... They show him a lot of respect. If he was a female he would probably be with me. But because he is a male they just have this way... it's not fair. Some of the traditions... they need to stop... towards women. Because it's just... women give so much and then to not get that respect in return is... it's just wrong.

I didn't get on with them... they just saw me as a caretaker and that's all. That's all I was there for. Just be a care taker, nothing else.
(MSPC11)

This same client described how her own CALD background relatives also shared similar beliefs concerning the role of women and how this affected her relationship with her son:

But it's the same as my own cultural background... [a Serbo-Croatian] and I have been brought up in a lot of conflict, I don't want him [my son] to be brought up like that... he is very fragile now because he is a teenager. So I have to be very careful how I approach him... so I just go easy. (MSPC11)

The support from elderly family who were overseas and the need to lessen their anxiety constrained one CALD client from being truthful to her parents about her circumstances of being at risk of homelessness:

Because my parents, they couldn't come here. I haven't been back [to Asia] for like three years now... I didn't tell them the whole story of my situation. But they know... a little bit about it, so I try not to let them worry about me... because they are now getting older and I don't want to let them feel anxious. (MSPC12)

6.3.1.3.3 Environment

The environment of an individual can enable or constrain their sense of being part of a community, being isolated or being able to change their lives thereby creating a sense of future. The clients in this study were all living in a busy capital city that could be a harsh environment particularly for people who were homeless or at risk of homelessness. The clients in the HSP were in a stable environment whereas for the women in the MSP, they were living in tenuous accommodation such as refuges, with friends or living in affordable private accommodation in environments that were less than adequate. One client commented on the difficulty of not being able to stay indoors when unwell at the refuge. This constrained her ability to become well. She also reflected on the lack of choice of accommodation and environment and not having anywhere to go during the day. The MSP enabled her and others an available environment to be themselves:

Well there are a lot of girls, ladies, that wouldn't have anywhere to go because they [refuge] like to shush them out the door daily. When I first read all the paperwork it was like five hours a day. And I have got emphysema so I cruised around, I didn't know about this place [The MSP]. I walked around the area and you know, for about nearly two hours, I thought I can't do it anymore... but there are a lot of ladies when they [refuge] really stick to that time they are all chased out the door... if they didn't have [The MSP] ... I mean if we had anywhere to go we would be there, you know what I mean, we wouldn't be at the women's refuge. (MSPC1)

Clients also described the difficult environment of private, affordable accommodation. One client was constrained by feeling overwhelmed when going in to Housing to discuss changing her situation.

I have my private housing... very cheap rent... But then there is also an old man that lives right adjacent to me... He has been a bit inappropriate at the beginning... I just don't like it there. I don't like him... And it's cold in there and it's dark and... Every time I go into the Housing office there is all these really strange people and it makes me think I don't know if I even want to go into housing but I can't stay where I am. It's just so overwhelming... (MSPC2)

This same client described how this environment affected her mental health:

... I ended up on anti-depressants because I just could not handle the lack of sleep. (MSPC2)

One of the clients recounted her employment background and the various environments. These included working in a flexible, less stressful environment, working with other women that enabled her to be productive:

I used to work in the factory environment... so I would like to do production work again. I have done computer courses... but I fitted in factory hand work. I don't need a lot of money a week... I need that flexible environment. Where it's not too much stress and too rushed... I like that environment. And I like working with the same people every day and there is a lot of different women working in that environment as well... (MSPC11)

Another client discussed the problem with instability and insecurity of her home environment. There was no feeling of safety or home and she was constrained by having no control over who would move in with her:

And where I am, at the Rocks where I am staying in [temporary public accommodation] ... it's okay, it's just... I don't know when someone will move in, I just get nervous about that, I don't feel like it's home. It's just a house. I don't feel like I have a safe home environment. (MSPC11)

However, in spite of the constraints experienced in the environment, the participants found solace and sanctuary being in the MSP. Clients in this study were successfully housed in the HSP and clients at MSP were being housed or lived in temporary accommodation mainly at refuges. Although during this time there was a complex interplay between clients, case managers and other staff there was a sense in the data that a healing process had begun for clients. This process involved clients now being able to talk about the experience of being housed in the HSP and to talk about the way in which the MSP was important to the clients' continual solace and sanctuary. The key aspects of this solace and sanctuary are being able

to create a sense of home, feeling secure, experiencing a sense of safety and future hope that lead to a sense of future.

At the MSP, most of the clients were in temporary accommodation but the need to have a place that felt like a home and for solace, being able to have a sense of security and peace was paramount to their future. One client commented:

... and then you can sort of sit out there and have a cup of tea or whatever and just feel, it feels really safe being here. (MSPC2)

The need to have a sanctuary where they could feel at peace with the world was summed up succinctly by one of the clients:

There is no feelings of you know, of danger or... being unsafe... I have seen that where girls, some women have gone at it with each other and they have been asked to leave and stuff. So there is always... always that sense of serenity and peace. (MSPC11)

Another client agreed and added that MSP was somewhere safe when there was no other place to go:

... it's nice to fill those days in sometimes... Whatever issues they are going through they are not able to get a job and so they have got somewhere to go, instead of just staying home if lucky or being bored... they come here in a safe setting and it fills their days. (MSPC11)

Another client believed that the most important thing in her life apart from a roof over her head was safety:

... because when you have a roof it just doesn't matter, the rest doesn't matter, because you are in a safe place. Nothing mattered to me, nothing. Not even where I was going to eat that day, a full meal or a cup of tea only, you know, so... the most important thing was... that you were away from what you feared and... the life of... where you don't have to watch your back all the time. (MSPC13)

Having a peaceful and secure place also meant for a number of clients, being at the MSP was a place where no men were allowed. This feeling of solace also included being able to relate to other women who have been through similar situations, that is, being fearful of men. A few clients reflect this:

If there were men here it would change... some women have a fear because of what they have gone through, they have a fear of being around men. They don't have that trust they would have with women because of their past situation... that's important... so... a lot of us relate to each other. We can... relate. (MSPC11)

And I think the healing of being with women around you is ... peacefully great because... there is no... male energy it... is so different. And now I come here and there is no men and... that makes me happy... that I can come to a women's only place. (MSPC13)

For me is it important that there are no men that come here absolutely... it's not that I hate men but I don't want to connect with them. Because... there is very few... men that I come across who just want to be a friend... They always want to go further than that. Like why would I want to?... I am happy there are no men here.

Because I am not wanting to connect, I am wanting to heal.
(MSPC13)

And it's also a safe place without men here... it's focussed obviously on women and women only. So it's a safe environment in that way for the women who come here. So it's good. (MSPC15)

Having a place that allows women to feel protected from past violence, allows the women to feel safety for the first time, lessening the stress in their very stressful lives. Three clients commented:

Leaving a domestic violent relationship, I was a nervous wreck. It was... an emotional thing... even though I went back to the marriage, walking away this time I found it was a lot easier, a lot... less stressful. I sort of knew where I was coming to. To the [MSP] I had somewhere to come to... (MSPC6)

Well I'm now finally feeling safe because my... husband doesn't know where I live. Though he decided to come back to me, after one of his women, because he had several during our marriage...
(MSPC9)

I feel a lot more safer... I don't have that fear of... past conflict... like I did with my ex... which is good. And that tension is gone which is good... and being with other women... we are all women... we sort of understand each other too. ... Some of us are from similar situations so... I feel a lot safer. I feel I have made the right choice. (MSPC11)

A number of health professionals also describe the MSP as a place of protection and safety, and the importance of only having a woman's service available. Two health professionals summed this up:

... it adds more of a protected sort of environment. There is a different set of issues that women face and to have workers specifically to talk about that with them is good. (MSPHP)

... it could be a potentially threatening environment, a stressful demanding environment where women may not feel comfortable. I think it's good to have a women's only service so they can have people who have an identified interest in working in that area... it benefits the client group... I think it just makes access a little less problematic for them here. (MSPHP)

Other case managers and health professionals described the MSP as an environment that is stable, secure and supportive where the clients are treated with dignity. Being able to be treated with respect and having positive role models for many clients has helped with healing and moving on with hope towards a future. They commented:

There are a lot of people whose only real contact with a safe, caring, predictable, stable point in life is the [MSP]. (MSPCM)

... it's [the MSP] sort of a supportive place they can go and there are groups there and it just has a warmer feel than other places (MSPCM)

I think everyone in the team is really supportive of each other (MSPHP)

It [the MSP] gives them more strength and support (MSPHP)

... the women there [the MSP] are treated as though, with dignity as though it's their own home. It's not here is a drug addict, here is a this, here is a that. It's here is Susie and here is Sharon. And it's the dignity. (MSPHP)

The importance of having a sense of protection available at [the MSP] was echoed by a number of the clients as being accepted into a sanctuary, a place with a sense of home, with underlying security.

Here at [the MSP] I feel secure with them. And I am sure not only me, but everyone. (MSPC3)

I am ever so glad because this place is... amazing. It's really fantastic to have a place like this to come to... just to be able to press the button and come in. And come and have... no worry about what, who, what, where, you are at. It's like coming into a home. ... They have given me peace... (MSPC13)

It's a home. It's like a... you feel safe, you feel warm and gives you a sense that everything will be ok... everything will be safe. (MSPC3)

I am building up this feeling of security because before that I was always worried that I have got no place, worried that I have got no way... and it's... so much because of here [MSP]. (MSP13)

While a number of clients leave MSP and move away to other suburbs, a number of them will keep involved with MSP. This MSP will be an environment they can return to if needed in the future. One client commented after being given a secure place to live:

So I have a semi consciousness feeling of security but if it all goes bad I will go back to [the MSP] and they will help me in one way or the other. ... I was really touched from the first time I came here, because I found a home away from home. ... It has helped me because there was so many fears in my life about starting up and knowing I was not... being on my own for too long. (MSPC13)

Another client at the MSP who was able to secure stable accommodation described how she was given hope of a future, which included her being able to come back to the MSP, and this helped clear obstacles in her way forward:

They told me here [at the MSP] don't give up. I can still come back here when you go to [permanent accommodation] and now I feel better in myself because I have got... there is a little bit of light instead of a brick wall. (MSPC4)

Discussion with another client centred on the importance of a peaceful environment which enabled them to be themselves. She also reflected about employment in a counselling role, and how having lived through this homeless experience with support from the MSP has given her some direction in her future career plans. She stated:

We all want to go somewhere where we enjoy being peaceful and are not intimidated... we should be ourselves... what I have experienced as a client here [at the MSP] will help me to then understand the clients that I can help in the future. (MSPC10)

The sense of being able to move on with their future and with their lives, the clients after being part of the MSP had a sense of surviving into the future. A metaphor one client used concerned the sense of being able to see 'light' in her future, and she acknowledged this:

I am now getting myself out of this situation. I will survive now... if you had seen me a year ago you would have said no. Because of being here at [the MSP] I have got some light at the end of the tunnel now. Because I thought I would be out in the street again. I did think

that but... but the girls here, the people I have only met here, have supported me (MSPC2)

The sense of future involved having a sense of hope and a sense that plans for the future would work out. Having the support from the MSP as well as her own faith, helped one of the client achieve this sense of hope:

Planning for my studies are fundamental, to my growth so to speak because I have to have some sort of hope to hang onto... especially in this sort of situation. So... my faith is my hope... but my future is also my hope. And without hope it's... very, very hard to exist... especially in the homeless, being homeless. Being here at [the MSP] has helped this. (MSPC15)

6.4 Chapter summary

In summary, the experiences of the participants encompass many enabling or constraining factors from personal, situational and societal dimensions, leading to an overall theme: A life-changing event: I have the power to change. Personal factors included health status, beliefs and attitudes, knowledge, and life and interpersonal skills. The situational factors included poverty, resources and services, and social support systems. The societal factors included gender, race and ethnicity, and the environment. The MSP allowed clients to have a better understanding of their power to change their life circumstances leading towards a better future. Purely by being in the MSP provided them solace and sanctuary. In the next chapter a discussion and conclusion to the study will be provided.

CHAPTER 7: DISCUSSION AND CONCLUSIONS

7.1 Introduction

In this thesis the experiences of people within a HSP and a MSP for people at risk of homelessness were presented. The specific objectives of the study were to report on the experiences of clients, case managers and housing support professionals who referred clients to a HSP and clients, case managers and health professionals within a daytime MSP for women.

This study was undertaken using a qualitative descriptive method to illuminate the perspectives of the participants in the two support programs. In this chapter, the findings are discussed alongside the Social Cognitive Theory framework and the broader research literature. The strengths and limitations of this study are reported, together with recommendations for future research and directions of support programs for vulnerable populations.

7.2 A life-changing event

The life-changing effect of the two programs was highlighted from the perspectives of the clients. They described both enabling and constraining aspects that contributed to the life-changing event.

The enabling aspects were facilitated by the involvement of the case managers. This involvement allowed them to be seen, heard and involved in the world around them. The clients had survived being homeless in

various forms in society and now had the opportunity to become part of mainstream society again through being part of these support programs.

Social Cognitive Theory guided the study where individuals react to certain situations and this influences a change in their personal, cognitive and behavioural outlook to life. These observations, within the framework of SCT, help to elucidate the experiences of the clients when they encounter difficult environments. The use of this theory helps to highlight the role of self-efficacy and regulatory behaviours including the challenges of engagement in support services.

Clients in the HSP and MSP experienced this life-changing event with two different outcomes. For the HSP clients, the life-changing event led to them reporting that they now had a home while for the MSP clients, the life-changing event enabled them to have the power to change. These two life-changing events within a social-cognitive framework allowed the client to move towards a sense of belonging to society and the future. Other participants within this study, that is, case managers, housing support professionals and health professionals, supported the clients' realisation of their life-changing event (See Figure 7.2).

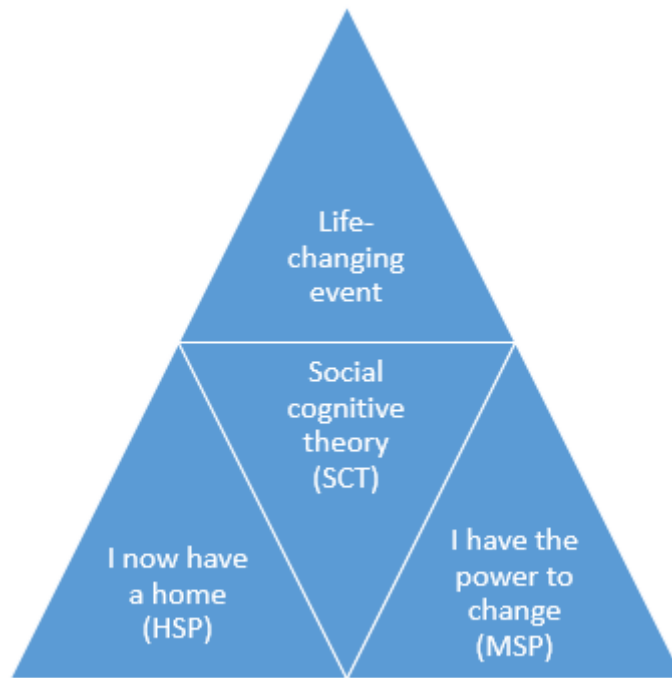


Figure 7.2: A life-changing event within a Social Cognitive Framework

7.2.1 A life-changing event: I now have a home

This life-changing event for the HSP clients consisted of three sub-themes: continuity of care, bridging the gap, and inclusion in the world enabled by the work of the case managers. People who are at risk of homelessness struggle as they try to maintain stable housing with their day-to-day existence as a result of a combination of physical and mental disorders (Fazel et al., 2014; Hwang & Burns, 2014). Many clients in this study struggled to maintain their physical and mental health. For some, their health status was exacerbated by substance use. Studies have shown that co-morbidity of mental health issues and substance use is common

(Cleary, Hunt, Matheson, Siegfried, & Walter, 2008; Hunt, Malhi, Cleary, Lai, & Sitharthan, 2016; Krausz et al., 2013; Lai, Cleary, Sitharthan, & Hunt, 2015). Health professionals who work in homeless services need to be cognizant of providing care that is collaborative and integrated, since, clients present with diverse issues. (Hwang & Burns, 2014). If strategies are put in place to ensure coordinated care such as access to support, individualised case management and appropriate treatment programs then these strategies could result in positive outcomes for the clients (Bruce et al., 2012; Crane, Warnes, & Fu, 2006; Hwang et al., 2005; Schanzer et al., 2007).

Other key components of care include positive interpersonal relationships, familiarity with community resources and being advocates for improvements to homeless healthcare (Hwang & Burns, 2014). In this study, the main advocates for the clients in the delivery of integrated and coordinated care were the case managers together with the health professionals. The clients described the case managers and health professionals as facilitating access, follow-up and re-assessment of their healthcare needs together with organisational support. Care that is coherent, linked, maintained and supported is fundamental to health improvement (Haggerty, Reid, Freeman, Starfield, Adair, & McKendry, 2003; Reid, McKendry, & Haggerty, 2002). Furthermore, if strategies are put in place to ensure coordinated, integrated care such as access to

support, individualised case management and appropriate treatment programs then these strategies are more likely to result in positive outcomes for clients (Crane et al., 2006; Flatau et al., 2010; Hwang et al., 2005; Schanzer et al., 2007). Currently emphasis is placed on integrated ongoing support services. Findings from Housing First demonstrate that in order to maintain permanent tenancy, recovery and stability, some individuals will always require ongoing intensive multidisciplinary support (Johnson et al., 2012).

In this study, the clients discussed how the case managers were involved in coordinating and prioritising their needs through linking with various resources and services. The case managers were aware of the challenges when dealing with the complex issues that the clients faced and they used holistic care. The case managers who came from a number of diverse backgrounds including social work, nursing and welfare, acknowledged the importance of the use of holistic care to facilitate appropriate referral to support structures. These aspects of holism which acknowledge the multi-dimensions of the individual are consistent with other literature which focussed on clinical practice through key elements of assessment, planning, goal development, intervention and evaluation (Kanter, 1989; Parahoo, 2014; Povlsen & Borup, 2011; Wilson & Neville, 2008). This literature was consistent within both Australian and overseas research (Evans, Drennan, & Roberts, 2005; Gronda, 2009; Marfleet et al., 2013;

Morales-Asencio et al., 2008; Wideman, Pizzello, & Lemke, 2008). In addition, the case manager has a vital role in supporting individuals with diverse, complex and multiple requirements within a supportive relationship framework (Zlotnick & Marks, 2002). Case management has been shown to improve satisfaction with care given in the community, in particular, for older people (Low, Yap, & Brodaty, 2011).

Case management needs to be non-judgemental, encouraging and have supportive managers who are respectful and committed to long-term care with their clients (McDonald & Coventry, 2009). This individual relationship, particularly in mental health research, which exists between the client and the case manager within the context of social support systems, is vital for case management to be successful (Hopkins & Ramsundar, 2005; Rapp & Goscha, 2003). The relationship between other service providers, including health professionals together with the case manager is of equal importance (Young, 2009). Throughout this study, all the participants articulated the importance of building relationships and the positive qualities that either the case managers possessed or to which they aspired. The varied skills required for case management which often required accepting the challenging nature of the work have also been documented in the literature (Dorsett & Fronek, 2009). The case managers had undertaken the case management challenge to enable constructive outcomes for the clients in this study. This involved working within a multidisciplinary team in a collaborative and cohesive manner.

The relationships between the clients and the case managers incorporated specific goal setting and encouragement within a safe and supportive environment. This could be seen in the development of increasing self-efficacy in clients by using verbal persuasion to encourage them to consider positive future options. The strategy of case management has been shown to increase housing retention and health treatment retention which are relevant to the clients in this study who had a history of diverse health and tenancy issues (Bedell, Cohen, & Sullivan, 2000; Bond, Drake, Mueser, & Latimer, 2001).

The clients in this study did have complex issues and they were assisted by the case managers in life skills management, organisational support and helping with hoarding and squalor concerns, and this mirrors clinical findings reported in the literature (Raeburn, Hungerford, Escott, & Cleary, 2015). Moreover, Flatau et al. (2010) suggested that the complex, diverse needs of clients can be addressed through an integrated and holistic case management approach so as to reduce the service gap often seen in fragmented service systems. However, integration initiatives have an impact upon the power, influence and authority of the individuals involved thereby impacting upon the coherence and cohesion of specific programs (Phillips, Milligan, & Jones, 2009). Integrated and comprehensive health care programs therefore need thoughtful planning and team consultation for positive outcomes to occur (Flatau et al., 2010; Horsfall, Cleary, & Hunt, 2010).

The type of housing in which they are living in can influence the way an individual interacts with, and feels about other individuals (Hulse & Stone, 2007). Once this house turns into a home, the interpretation of the meaning of home can encompass individual memories and nostalgic feelings, emotional experiences and sensory perception (Shelter S.A. Project, 2008). Dyck, Kontos, Angus, and McKeever (2005) concurred that the term home conjures up personal, cultural, social, and political meanings for an individual. In some literature, home is a place of origin or a feeling of belonging, dependent on interactions and relationships or geographical location (Hayes, 2007; Madison, 2006) or a means of self-identity for the occupiers within a secure environment (Fox, 2002; Mallett, 2004; Walter, 2008).

The clients in this study described finally being able to feel some safety and security after periods of homelessness and being vulnerable to assault. The feelings of freedom and independence to have a place of their own or hope of finding a secure home has been described by the clients in this study as providing a new lease of life, a changed life. This life included socialising with others and forming relationships that can create and maintain a sense of self in these individuals. In turn, interacting with others in social situations can impact on self-confidence and coping strategies and decrease negative reactions to stress such as physical illness and depression (Bandura et al., 2007).

A positive and significant aspect of self and sense of identity, particularly for older people, is closely linked to their own perception of independence and maintenance of a home, which can give purpose to their lives (Tanner, 2001). In fact, changing perceptions of homeless people has facilitated transition off the streets, in these people (MacKnee & Mervyn, 2002). The HSP and the MSP was portrayed by both the clients and the participants as enabling clients to become self-reliant and empowered particularly concerning relationships with others. Clients also became optimistic about the future and realised that this involved taking responsibility for their lives. All the participants ascribed to the HSP, the re-establishment of self-confidence and self-worth and being able to undertake interests again.

7.2.2 A life-changing event: I have the power to change

This theme was supported by three sub-themes: personal factors, societal factors and situational factors that led the clients to have a life-changing event by being empowered to change. The clients now have the belief in their own capability in achieving goals and overcoming obstacles using inner, accessible resources involves self-efficacy and self-agency. In this study, aspects that provided clients with a sense of self-agency, affected their self-efficacy and these were the personal factors of belief and attitudes. Individuals have a diversity of beliefs and attitudes that develop throughout life, contributing to their own worldview. Our beliefs and attitudes can underpin our reactions in life. Some beliefs will engender a

sense of accomplishment and a feeling of security in the ability to complete and manage challenges. Alternatively, some beliefs and attitudes can constrain the confidence to move forward in an individual (Bohner & Dickel, 2011; Christian, Abrams, Clapham, Nayyar, & Cotler, 2016).

For example, being ill can challenge an individual's belief system and conversely, being healthy can imply a new beginning. Wanting to stop being unwell involves being ready to change attitudes and past beliefs, it is about being ready to change and having support while undergoing this change. Self-efficacy beliefs and expectations which underpin personal agency, influence whether an individual can perform a certain action by undertaking health checks, following up appointments and persevering with treatment (Bandura, 1989; Bandura, 2006). There are four sources of self-efficacy to help with interpreting information and which affect self-efficacy: mastery experience, verbal persuasion, vicarious experience and physiological states (Bandura et al., 2007). These four sources can be seen as self-reflections on personal performance and are closely linked to motivation levels (Bandura, 1977).

As mentioned previously, clients within the MSP faced varied health needs within their environment that reduced their self-care and motivation, in turn reducing their self-efficacy. Self-efficacy occurs on a continuum ranging from high to low. Individuals who are on the lower end of the continuum have reduced ability to make adaptive changes in their lives (Bandura,

2004). Verbal persuasion, (part of the development of self-efficacy), such as, the encouragement of knowledge acquisition and goal setting, was facilitated by the caseworkers in the MSP as in a supportive environment. Health promotion educational activities in the MSP encouraged clients to improve their health status and maintain their health, in difficult circumstances.

Clients gained knowledge not only from case managers and health professionals but also from other clients, from past experiences and had role models that passed knowledge onto them concerning support services (Cleary, Horsfall, Hunt, Escott, & Happell, 2011). Through verbal persuasion, clients were encouraged and persuaded to continue learning and to remain optimistic concerning their future and this involved strengthening interpersonal skills within and between clients, health professionals and case managers. Interpersonal relationships were developed through effective communication (Cleary, Hunt, Horsfall, & Deacon, 2012), interpersonal self-perception and problem solving can result in coping with stressful events in one's life (D'Zurilla & Chang, 1995; Erözkan, 2013). The clients in this study discussed coping and remaining strong and self-reliant while being involved in the life and interpersonal interactions around them within the MSP.

The findings from this study illustrated how the situational and structural factors of poverty constricted the ability of clients to move forward. This

meant that many of them needed support with organising financial assistance, particularly within the HSP. Budget considerations were also part of the maintenance of on-going care provided by the case managers. Engaging the clients in organising their daily or weekly appointments and activities gave the clients confidence, independence and involvement in other facets of life.

For the MSP clients, their cultural background and their perceived ability to cope in harsh, demanding environments had an impact on either being able to move forward in life, being constrained, or indeed remaining stagnant. They encountered stigma, social inequity and trauma through violence and abuse. Traumatic events can cause loss of hope, and impacts on a positive outlook for the future (Chamberlain et al., 2007). Many of the clients in this study reported that they were affected by traumatic events including sexual trauma, domestic and family violence, psychological trauma and abandonment. Homeless people who have been involved in traumatic events, require the use of trauma-informed approaches to services and thus, staff development in this area is necessary (Cleary & Hungerford, 2015; Robinson, 2011). These traumatic events initially constrained clients from moving through past events. However, they later recognised that they could have a life-changing event by being empowered to change and this led to developing a better sense of their future. This was encouraged by being in the MSP and being supported by the case managers.

The environment for all clients within this study, until being settled into stable tenancy or temporary accommodation, was stressful and diminished optimism, hope and incentive to continue. Self-efficacy for the clients can be reduced as perception and motivation are negatively affected (Bandura et al., 2007). One of the sources of self-efficacy, vicarious experiences with influential role models can impact on thinking differently and optimistically about a challenging situation (Bandura et al., 2007; Washington & Moxley, 2013).

The ability to access information and resources including personal and financial support facilitated by case managers and health professionals within stable or temporary accommodation allowed the clients to reconsider and reflect upon their position in life. In response to the constraining and enabling aspects in their lives, clients moved towards life-changing events and dimensions that further developed and influenced their sense of future.

The case managers discussed the importance of successfully empowering the individual through autonomy and having control in various situations. This also involved advocacy. The case managers were included in advocacy by having client - centred interactions, bridging the gap of service provision and working on behalf of the interest of the clients. Advocacy includes valuing, informing, advising, educating an individual and interceding on their behalf when necessary (Baldwin, 2003). Furthermore, case managers need to work within a case management model of care.

Case management involves negotiating, working alongside a client, being persistent, recognising and encouraging strengths within clients and ensuring mutual decision making (Juhila, 2008). Practice guidelines for Specialist Homelessness Services (SHS) practitioners include an emphasis on a client-centred approach focusing on building capacity, advocacy, living skills, support, building resilience and community partnership and connections for the client (Specialist Homelessness Services (SHS), 2015).

Through the HSP and the MSP, the clients were exposed to another source of self-efficacy, vicarious experience and role modelling by interacting with case managers, health professionals and other clients in the programs. These interactions contributed to acting as a guide for future action on behalf of the clients, helping the individual with ways of coping with the environment or situation in which they found themselves and at times, transcending these situations (Bandura et al., 2007). Role modelling involved the case managers building capacity for the clients, for example, in working alongside the clients to help them to gain independence and expecting the clients to accept responsibility for their actions. This role modelling increases their confidence and knowledge. The clients explained how the case managers helped facilitate decision-making skills instead of taking over and making decisions for them, which other agencies had done in the past. This was seen by the clients as empowering them to act independently. Basic human rights such as privacy and autonomy in decision making and improvements in social status of oppressed or

vulnerable individuals, strengthen advocacy (Freddolino, Moxley, & Hyduk, 2004; Hamric, 2000). Furthermore, advocacy also has the reinforcing concepts of the client's right to information, self-determination, and the right to personal safety (Raeburn, Schmied, Hungerford, & Cleary, 2016; Vaartio & Leino-Kilpi, 2005).

In order to obtain access for clients to essential community resources, case managers needed to be persistent in their interactions with other service providers (Juhila, 2008; Young, 2009). The case managers in this study persisted with other service providers to obtain the best outcomes for clients. This involved sometimes working with challenging issues in high conflict situations, making sure mutually agreed goals were met. The clients in this study indicated that the case managers persistently stood up for their rights, took their concerns seriously and made sure that they were receiving appropriate services. Clients who were in vulnerable situations may have forgotten or may not have had the skills or confidence needed to liaise with health care and other services. In such circumstances, these clients required the support of an advocate to negotiate the way. Being involved in different partnerships with care providers also involved the client in the decision making process. This type of personal advocacy and partnership could help the client to gain the skills of decision-making and/or empower the client.

The protection and promotion of client's rights in regard to involvement in decision making has been discussed by Baldwin (2003) as one of the attributes of advocacy. The use of health advocacy as an early intervention tool for improving health-related and social needs of homeless people has been documented (Graham-Jones, Reilly, & Gaulton, 2004). The interventions included primary healthcare services information and access; allowing time to talk to clients, providing practical help as well as liaison and referrals with and to other agencies as required on behalf of the clients.

Findings that related specifically to clients within this study included an increased knowledge and understanding of self. Clients described key aspects of this understanding relating to their self-identity, their self-esteem, their confidence and re-establishment of themselves as individuals. Homelessness and being without prospects, caused many of the clients to question their own identity. Understanding of integrity of self and assurance of security of person is intertwined with an individual's ability to have some control over their home environment (Dyck et al., 2005). The understanding of self in this study by the clients involved acceptance of dealing with problematic issues that arose instead of running away from them. Having their own home because of the HSP or being in temporary accommodation when involved in the MSP allowed the clients to begin understanding their situation and take more responsibility for their well-being and tenancy issues. They gained control over their lives and began

to participate as part of mainstream society because having their own home helped the client to achieve a life goal i.e. gaining or maintaining a home of their own. The achievement of this personal goal, led the clients to develop self-confidence in their own abilities, their self-efficacy improved, and they experienced an increasing sense of achievement and a re-establishment of self.

Self-esteem and self-confidence are related to concepts of self-efficacy. Self-esteem is one of the basic human motivations that individuals need; esteem from other people as well as inner self-respect to grow as a person (Maslow, 1987). Self-confidence is a belief in one's own ability to complete expected outcomes and belief that one is capable and competent in achieving this outcome (Bandura, 1982). Self-efficacy however involves a belief or judgement in your own ability and performance to achieve future actions (Bandura, 1982). The level of confidence within a person can influence the level of self-efficacy.

A sense of being in control of one's own life i.e. having a sense of personal control or changing beliefs in regard to personal control can assist an individual to use suitable coping strategies to achieve goals (Epel et al., 1999). Personal efficacy or belief in one's own abilities in applying effort in achieving a goal together with self-esteem, a readiness to learn and a positive social identity, influence an extensive range of social and health outcomes (Friedli & Organisation mondiale de la santé, 2009). An

individual's subjective appraisal of coping ability with environmental demands of stressful circumstances is seen as coping self-efficacy. A reduction in vulnerability to stress and depression can occur by having a strong sense of coping efficacy and this strengthens resilience in difficult times (Bandura, 1997; 1977). The client's involvement in the MSP lessened their stress and supported their development of stronger coping mechanisms. This positive change in their life experience, made them optimistic about the future.

Gronda (2009) established that being able to empathise, understand and accept clients and have a respectful, reliable and persistent relationship have been shown as effective case management practices when working with homeless people. In this study, connecting with and establishing collaborative partnerships within resources was organised through the case managers, firstly developing relationships with the clients, then with people who referred clients together with health professionals. These interventions assisted in overcoming barriers that existed in connecting homeless people with appropriate services.

In this study, the case managers and housing support professionals who referred clients suggested a number of collaborative practices. These included the need for information exchange between services such as housing, health services and other social agencies. Other practices which were important were the need for strategies to monitor vulnerable at risk

people, to organise daily living activity for clients and to assist clients with organisational management. According to Crane et al. (2006) communication between agencies and implementation of strategies to assist people at risk of loss of tenancy has the best potential to produce quality outcomes for clients.

The findings from this study revealed that developing collaborative relationships with referral agencies were evident in the everyday activities of the case managers. In many instances, the information exchange that occurred in these relationships supported the clients and their tenancy. Several studies (Allen, 2006; Coleman & Rummery, 2003; Rota-Bartelink & Lipmann, 2007) have found that developing professional relationships assisted in the delivery of care to clients, especially for older people. Other studies (Kunnen & Martin, 2004; Vogel, Ransom, Wai, & Luisi, 2007), found that interlinking professional relationships were essential for facilitating accurate assessment for clients in assisted accommodation for the homeless.

The housing support professionals who referred clients identified the ease of contact and partnership they had with case managers and observed the rapport and relationship that existed between the clients and case managers. They asserted that this contributed to engaging the client in the programs, resulting in organising and maintaining tenancy. Long-term relationships between service providers and people who are homeless or at

risk of homelessness involving trust and respect. This has been identified as an important component of the engagement process (Darbyshire, Muir-Cochrane, Fereday, Jureidini, & Drummond, 2006; Moore, Gerdtz, Hepworth, & Manias, 2011; Wen, Hudak, & Hwang, 2007).

The case managers were also involved in early intervention when problems arose for their clients, they were proactive in supporting the clients. The case managers believed that it was better to be proactive in management of issues for the client rather than reacting to emergencies, since this could lead to eviction or exacerbation of other issues (Kempshall, 2010).

The clients discussed how the case managers facilitated their involvement in the world and the case managers reported the importance of this inclusion. The general population takes for granted the ability to relate and connect with others, to have confidence to be with others and to have their own personal space. The clients in this study had lost personal skills due to life circumstances such as loss of income, loss of tenancy and or illness. Both programs facilitated the regaining of the skills to move out into the world.

Clients described being able to connect again and becoming interested with other people around them. Many clients depicted the loss of their own family and friends and finding new ones within the HSP and the MSP. The engagement with the case managers supported the participants to commence involvement and socialisation with others, to build relationships

and to have someone to turn to in times of difficulty. Reconnecting an individual who has been ostracised and living in a marginalised community towards a community of caring is imperative for social inclusion and healing to occur (Christensen, 2009).

One of the aims of the social inclusion framework is to help individuals, particularly those who do not fit into mainstream society, to access support, connecting and reconnecting with opportunities in society (Australian Social Inclusion Board, 2010). The emphasis is on connecting people with local community resources and integrating service provision and capacity building particularly in the area of housing management and reduction of homelessness (Australian Social Inclusion Board, 2010; Hulse, Jacobs, Arthurson, & Spinney, 2010). Social inclusion policies have shown the need to have a holistic approach to establish links across service provision sectors (Hulse et al., 2010). Individuals need to become connected within communities so as to achieve or retain social recognition, which can contribute to resilience and better mental health (Cleary, Horsfall, & Escott, 2014; Friedli & Organisation mondiale de la santé, 2009). Lack of social reintegration of individuals who have been marginalised by mainstream society has been seen as a limitation of the Housing First approach to addressing long-term homelessness (Johnson et al., 2012).

The case managers and health professionals within this program promoted social inclusion, socialisation and relationship building for clients, which

was viewed as important for reintegration, and is consistent with the literature (Casey, 2014). Individuals who are experiencing loneliness lose confidence in having social encounters with others. Therefore, increasing opportunities for social interaction within existing community structures may assist in decreasing social isolation (Franklin & Tranter, 2011). The case managers in this study understood the importance of social interaction and the need for meaningful relationships. They recognised that the clients were lonely and this could lead to depression and despair. The clients appreciated the many and varied opportunities for social activity offered. Furthermore, being involved with others, particularly having contact with people who had similar problems and issues persuaded clients to become involved in the available social activities and groups within the HSP and the MSP. This is consistent with literature that suggested when addressing loneliness, it is the quality of the relationship, while addressing the specific needs of individuals, rather than only the presence of others that matter (Jaworski & Moyle, 2008; Wilson, Cordier, Parsons, Vaz, & Buchanan, 2016).

Connecting with others is an important component of being able to feel part of the community again. The clients, particularly with mental health issues, have stated that being involved in the HSP and MSP supported them to reconnect with others and to feel socially included, and this had been pivotal in keeping them alive. The social inclusion framework offers a positive collective approach towards a mentally healthy individual and

community (Merton & Bateman, 2007). Although to work realistically, social inclusion policies need to address other social and economic policies examining poverty, employment and education for the vulnerable in society (Stickley, Hitchcock, & Bertram, 2005).

Prior to entering the HSP and the MSP, the clients in this study were constantly under stress. They were homeless and socially, financially and psychologically disadvantaged. It can be physically and mentally wearing, on an individual who is constantly under stress and this increases the allostatic load. Allostasis (which is an expansion of the homeostasis concept) explains the physiological response to stress. Chronic illness and pathology can occur because of failed adaptation or allostasis (Carlson & Chamberlain, 2005; Logan & Barksdale, 2008; Macer, 2006; McEwen & Bruce, 2004). Conversely, a strong influence on positive health outcomes would be personal control, a sense of being able to manage one's own life (Macer, 2006).

A sense of being in control of one's own life i.e. having a sense of personal control or changing beliefs in regard to personal control can assist an individual to use suitable coping strategies in order to achieve goals (Epel et al., 1999). Personal efficacy or belief in one's own abilities in applying effort in achieving a goal together with self-esteem, a readiness to learn and a positive social identity, influence an extensive range of social and health outcomes (Friedli & Organisation mondiale de la santé, 2009). An

individual's subjective appraisal of coping ability with environmental demands of stressful circumstances is seen as coping self-efficacy. A reduction in vulnerability to stress and depression can occur by having a strong sense of coping efficacy strengthening resilience in difficult times (Bandura, 1977; Bandura et al., 2007).

The case managers and health professionals in homeless support programs for people at risk of being homeless are encouraged to instill hope and belief that clients are worthy of a better life (Montgomery, McCauley, & Bailey, 2009). In addition, service and care providers involved in homeless support programs need to acknowledge the challenges ahead for the clients and that they need to take small incremental steps to develop future prospects. This will assist them in avoiding lapses back into homelessness (D'Amico, Barnes, Gilbert, Ryan, & Wenzel, 2009; Magee & Hurliaux, 2008). The development of new skills such as communication skills, goal setting and decision making skills, living skills and financial acumen have the potential to improve employability and increase perceived competency and self-efficacy for people who are at risk of being homeless (Fingeld-Connett, Bloom, & Johnson, 2012). In the HSP and MSP, the development of new skills was encouraged by the case managers and health professional and could be seen as proactive and sustaining programs for working with this vulnerable population.

7.3 Summary of key findings

The study findings have contributed to the development of new knowledge concerning the experiences of people involved in a Housing Support Program (HSP) and a Maintenance Support Program (MSP) for people who are homeless or at risk of becoming homeless. The experiences of the clients have been explored within the Social Cognitive Theory (SCT) framework which has elucidated the difficult environment for this vulnerable population. In addition, SCT was used to identify facilitating and constraining factors to explore the personal attributes and the behavioural outcomes of the clients within this environment, together with the challenges experienced when engaging with support services. The outcomes of this study provide a revealing contribution to the knowledge base within the field of case management, supportive housing and maintenance programs.

The main finding related to the objectives, is that, through the involvement of case managers and health professionals within a HSP and a MSP, a life-changing event occurred. The life-changing event for clients involved in the HSP, was that they now had a home. This life-changing event occurred through the involvement of case managers in continuity of care, leading to bridging the gap in service provision for the clients, together with facilitating the clients' inclusion into the world around them. The findings therefore resonate with the literature, that homelessness comprises of several

dimensions and the life of people within these dimensions need to be viewed within a whole of life story. This multi-storied complex relationship between the individuals who are homeless or at risk of being homeless, together with the services provided by the case managers and other health providers within these two programs, has been revealed.

Case management encompasses personal involvement and resolute guidance within co-ordinated, collaborative and integrated care. This care alongside established services, provided improved client outcomes. Furthermore, advocating for the client, facilitating access to appropriate treatment involving multidisciplinary, holistic care, together with committed goal setting by the client equated to effective case management. The findings concerning the holistic case management approach for the clients has built upon, and extends the literature concerning service provision provided by non-government organisations within the housing sector.

The case managers, together with the health professionals within the program facilitated the development of relationships incorporating respectful, encouraging, committed and non-judgemental attitudes. These attributes within supportive relationships, linked with achievable goal setting, socialisation, and responsibility for their own lives, allowed re-establishment of self-confidence and self-worth in the clients.

Within the MSP, the clients had time to reconsider and review their lives. The clients reviewed their constraining and enabling factors from their

personal as well as situational and societal circumstances. The life changing event for the MSP clients was the realisation that they had the power to change. This enabled them to move towards developing a sense of future.

This development involved the clients' belief in their own capabilities, their inner resources and sense of accomplishment to improve, thereby affecting their personal self-efficacy and self-agency. As surmised in the SCT literature, improvement in self-efficacy has important implications for influencing and managing future choices together with motivation for activating and sustaining change of the individual within the environment (Bandura, et al., 2007). Additionally, health promotion and educational activities within the program related to health improvements and motivation levels contributed to strengthening clients' interpersonal skills. These included remaining strong, developing and maintaining optimism through the contact and encouragement of the case managers, health professionals and other effective role models. An appreciation of the importance of integrative and productive relationships with case managers, healthcare providers and others within these support programs has been demonstrated.

The participation of the clients in the programs allowed for time to address issues of cultural concerns, stigma, social inequity, trauma, violence and abuse. The clients were able to work on building resilience and effectual

relationships within a community of solace and security. This enabled them to improve and re-establish a self-identity, and build confidence and self-esteem. They were supported by those who helped with early intervention, access to information, practical help, and referrals. The clients were involved in decision making, strengthening their advocacy, autonomy and self-determination in the process. As discussed within the findings, a reinforcement of these concepts allowed case management to be successful and sustainable. Moreover, early engagement by the case managers, together with a proactive approach, empowered the clients through integrated service provision and capacity building. The promotion of social inclusion and decreasing social isolation facilitated the clients' societal reintegration, and enabled them to move towards an achievable future. The multi-dimensional team approach emphasising the whole of life story of the individual allowed clients to develop a sense of future, facilitated by successful involvement in the program and supportive case managers and health professionals.

Ensuring continual, successful outcomes for the journey from homelessness to sustainable, successful housing, the on-going support with the involvement of interested, dedicated and concerned people within a team approach is vital, as reiterated within the literature. Certainly this study shows that the housing and maintenance programs for clients who are homeless or at risk of being homeless are successful if the case managers and health professionals work alongside the client uncovering

the personal, environmental and behavioural factors that impede their reintegration into society. These supportive programs allowed the clients to set goals, make informed decisions and most importantly, empowered the clients to begin anew, to develop self-confidence, to accept events that were life-affirming and indeed life-changing.

7.4 Strengths and limitations

An important strength of this study was the inclusiveness of the experiences and perspectives of clients, case managers, housing professionals who refer clients and health professionals. There is a paucity of research within Australia and overseas exploring the experience of stakeholders within housing support programs and maintenance support programs. This study has given a voice to, a vulnerable population and their experiences of support programs as well as to the case managers and housing professionals who are involved in client referrals. It also includes health professionals involved in the HSP and MSP provides meaningful insights into the importance of these two programs. The use of face-to-face interviews and focus group has enabled an in-depth understanding of the mechanisms underpinning support programs for people at risk of being or who are homeless.

The results of this study have limited generalisability as only one housing support program and one maintenance support program, in not for profit organisations was explored. Within the HSP and the MSP, the individual

sample size of the clients, case managers, housing professionals who refer clients and health professionals was relatively small. Additionally, the participants were self-selected. Therefore, the opinions and experiences of the participants may not reflect all people involved in other housing or maintenance support programs for people at risk of being homeless.

7.5 Implications and recommendations

The experiences of clients, case managers, housing professionals who refer clients and health professionals within these housing support and maintenance support programs can inform similar research undertaken for people at risk of being or who are homeless. Although people who are at risk of being homeless, have had an opportunity to give their perspectives of being in a housing support and maintenance support program, the longer term outcomes for these people as well as the programs remain unknown.

Longitudinal research concerning the clients involved in these programs, together with service providers and professionals who refer clients from within the housing, health and community sector will give further evidence concerning the benefits of support programs. Longitudinal studies that are undertaken over a number of years incorporating correlational research between factors such as time being involved in a housing support or maintenance program and employment opportunities could be considered. Larger mixed method studies incorporating intervention and evaluation studies by the use of questionnaires, surveys and interviews and focus

groups are recommended. These studies could be undertaken with service and care providers within programs for people at risk of being homeless. Further investigation into innovative interventions to increase service provider integration together with centres or programs in different geographical areas with diverse populations is suggested (Tabol et al., 2010). Suitable resources together with sustainable funding need to be established for this to be achieved.

Ongoing research relating to best practice for both men and women within these programs are necessary in order to build upon the knowledge base within current literature concerning programs for homeless people. Research into specific programs that target subgroups within this vulnerable group such as homeless youth support programs, prevention and early intervention programs, programs related to trauma informed care and services for domestic and family violence is necessary. Cross-sectional studies which could compare many variables such as age, gender, educational level and time involved within a housing support or maintenance support program would also add to knowledge concerning the viability of such support programs.

There were volunteers within the MSP program. Research that incorporates the use of the volunteers' own voice by means of qualitative research would contribute to more of an in-depth understanding of the volunteers themselves. Future research that can be undertaken includes

examining the sustainability of the volunteer role in various not for profit organisations by undertaking a comparative analysis of similar organisations such as the MSP where volunteers are involved. In addition, other types of support programs including support refuges with both mixed and single gender clients could be researched by qualitative and mixed method design. New perspectives on the volunteer experience not just on a personal level but how volunteering strengthens the community as a whole could be examined, illuminated and revealed.

Finally, as a personal reflection on this research journey, the service providers working within these intensive and challenging programs for vulnerable populations require acknowledgement and housing and maintenance support programs for people who are homeless need to continue and improve.

7.6 Conclusion

This study had the purpose of exploring, describing and reviewing the experiences, expectations and perceptions of stakeholders (clients, case managers, housing professionals who refer clients to a program and health professionals) who were involved in two support programs for people who are homeless or at risk of being homeless. The study investigated the stakeholder experiences to depict how these support programs functioned, how they were supportive to clients and overall assessment of each program through the perception of the stakeholders.

The specific research questions were answered and acknowledged that clients who are homeless within a HSP and a MSP have multiple and diverse needs and face numerous challenges to achieve their goals. As a result, being able to have a home was achieved within the HSP through the facilitation by case managers, health professionals involved in continuity of care, bridging the gap in services and this led to regaining inclusion into the world for the client. Many aspects embedded in the individual life of clients can either enable or constrain them from identifying and taking part in a life-changing event within both the HSP and the MSP. These enabling and constraining aspects included personal factors, situational factors and societal arrangements.

The conceptual framework of Social Cognitive Theory provided a way of understanding the personal, environmental and behavioural factors that influenced the choice of pathways in life clients accepted and /or rejected towards a life-changing event occurring, allowing a sense of future. Together with self-regulation of behaviour and sources of self-efficacy, clients may be able to understand the role that inner strengths or enabling aspects have in contributing to positive choices of pathways in life. An appreciation of this theory may also assist service providers in understanding their clients and their own selves within their relationships and collaborations with other service providers.

The findings, inferences and conceptual framework of this study pertaining to housing support and maintenance support for people who are homeless has contributed to the existing literature. The promotion of further research into policy and practice development within this area of need is warranted.

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APPENDICES

APPENDIX 1: Information Letter to Participants (Clients)

Information Letter to Participants

Dear Sir/ Madam,

You are invited to participate in an interview to assist in the evaluation of the Housing Support Program at [REDACTED]. This interview will take approximately 40 – 60 minutes of your time and will take place at your convenience. The demands of being a participant will include the time given to an interview. There are no perceived benefits to you of being involved in this project. The questions relate to your experience as clients within the Housing Support Program.

This study is being conducted by Professor Sandy Middleton, Dr Rhonda Hawley and Rose McMaster from the School of Nursing (NSW & ACT), Faculty of Health Sciences, Australian Catholic University (ACU) National. The Human Research Ethics Committee at ACU National have approved this study. Participation is voluntary and, should you decide not to participate or to withdraw at any time, your decision will be respected and will not prejudice your present or future relationship with [REDACTED]. All participants have been allocated a unique code number that will be used only to monitor the response rate. All information will be stored securely and archived in accordance with the National Health and Medical Research Council recommendations. Information obtained from this survey will eventuate in a research report and publications. No individual participants will be identified in reports or publications.

If you have any further questions, please contact Rose McMaster on (02) 9739 2369. This information sheet and a signed copy of the consent form is for you to keep. Results from this study will help inform staff involved in the Housing Support Program at [REDACTED] and the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) who are funding the project. We hope you will agree to participate.

Yours sincerely

Professor Sandy Middleton
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Dr Rhonda Hawley
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Ms Rose McMaster
School of Nursing (NSW & ACT)
Faculty of Health Sciences

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator has not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee, c/o Ms Kylie Pashley, Research Services, ACU National, PO Box 456, Virginia, QLD, 4014. Tel: 02 9701 4159, Fax: 02 9701 4350. Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

APPENDIX 2: Participant consent form (Client)

I (the participant) of

..... (address)

(.....)..... (day-time phone number)

have read and understood the information provided in the Participant Information Letter. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity by being interviewed, realising that I can withdraw at any time. This interview will take approximately 40 – 60 minutes of your time and will take place at your convenience. I understand that all information will remain confidential. By signing my name, I indicate that:

- I consent to the audio-taping of the interview.
- I agree that the research team may access my clinical data from records held at [REDACTED].
- I consent to the collection, processing and reporting of my personal sensitive information for healthcare/research purposes. All data will be de-identified, therefore not including my name, address or phone number. My information will be identified by a numerical random code.
- I understand that my unique study number will identify my information. This information is potentially identifiable but precautions will be taken by the research team to ensure the information will be kept confidential.

NAME OF PARTICIPANT (block)

Signature..... Date.....

Research team

Professor Sandy Middleton
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Dr Rhonda Hawley
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Ms Rose McMaster
School of Nursing (NSW & ACT)
Faculty of Health Sciences

APPENDIX 3: Information Letter to Participants (Case Managers)

Information Letter to Participants

Dear Madam,

You are invited to participate in an interview to assist in the evaluation of the Housing Support Program at [REDACTED]. This interview will take place at your convenience, and last approximately 60 minutes. The demands of being a participant will include the time given to an interview. There are no perceived benefits to you of being involved in this project. Questions relate to your experience as case manager working within the Housing Support Program.

This outcome study is being conducted by Professor Sandy Middleton, Dr Rhonda Hawley and Rose McMaster from the School of Nursing (NSW & ACT), Faculty of Health Sciences, Australian Catholic University (ACU) National. The Human Research Ethics Committee at ACU National have approved this study. Participation is voluntary and, should you decide not to participate or to withdraw at any time, your decision will be respected and will not prejudice your present or future relationship with [REDACTED]. All participants have been allocated a unique code number that will be used only to monitor the response rate. All information will be stored securely and archived in accordance with the National Health and Medical Research Council recommendations. Information obtained from this study will eventuate in a research report and publications. No individual participants will be identified in reports or publications.

If you have any further questions, please contact Rose McMaster on (02) 9739 2369. This information sheet and a signed copy of the consent form is for you to keep. Results from this study will help inform staff involved in the Housing Support Program at [REDACTED] and the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) who are funding the project. We hope you will agree to participate.

Yours sincerely

Professor Sandy Middleton
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Dr Rhonda Hawley
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Ms Rose McMaster
School of Nursing (NSW & ACT)
Faculty of Health Sciences

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator has not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee, c/o Ms Kylie Pashley, Research Services, ACU National, PO Box 456, Virginia, QLD, 4014. Tel: 02 9701 4159, Fax: 02 9701 4350. Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

APPENDIX 4: Participant consent form (Case Manager)

PARTICIPANT CONSENT FORM

I (the participant) of

..... (address)

(.....)..... (day-time phone number)

have read and understood the information provided in the Participant Information Letter. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity by being interviewed, realising that I can withdraw at any time. This interview will take approximately 60 minutes of your time and will take place at your convenience. I understand that all information will remain confidential. By signing my name, I indicate that:

- I consent to the audio-taping of the interview.
- I consent to the collection, processing and reporting of my personal sensitive information for healthcare/research purposes. All data will be de-identified, therefore not including my name, address or phone number. My information will be identified by a numerical random code.
- I understand that my unique study number will identify my information. This information is potentially identifiable but precautions will be taken by the research team to ensure the information will be kept confidential.

NAME OF PARTICIPANT (block)

Signature..... Date.....

Research Team

Professor Sandy Middleton
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Faculty of Health Sciences

APPENDIX 5: Information Letter to Participants (Focus Group)

Information Letter to Participants

Dear Sir/ Madam,

You are invited to participate in a focus group to assist in the evaluation of the Housing Support Program at [REDACTED]. This focus group will take approximately 60 minutes. The focus group will be held at ACU National, North Sydney on _____ (date to be subsequently arranged).

This focus group will consist of questions relating to the questionnaire and your experience as people who refer clients to the Housing Support Program team. The demands of being a participant will include the time given to this focus group. There are no perceived benefits to you of being involved in this project.

This study is being conducted by Professor Sandy Middleton, Dr Rhonda Hawley and Rose McMaster from the School of Nursing (NSW & ACT), Faculty of Health Sciences, Australian Catholic University (ACU) National. The Human Research Ethics Committee at ACU National have approved this study. Participation is voluntary and, should you decide not to participate or to withdraw at any time, your decision will be respected and will not prejudice your present or future relationship with [REDACTED]. All participants have been allocated a unique code number that will be used only to monitor the response rate. All information will be stored securely and archived in accordance with the National Health and Medical Research Council recommendations. Information obtained from this survey will eventuate in a research report and publications. No individual participants will be identified in reports or publications.

If you have any further questions, please contact Rose McMaster on (02) 9739 2369. This information sheet and a signed copy of the consent form is for you to keep. Results from this study will help inform staff involved in the Housing Support Program at [REDACTED] and the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) who are funding the project. We hope you will agree to participate.

Yours sincerely

Professor Sandy Middleton
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Dr Rhonda Hawley
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Ms Rose McMaster
School of Nursing (NSW & ACT)
Faculty of Health Sciences

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator has not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee, c/o Ms Kylie Pashley, Research Services, ACU National, PO Box 456, Virginia, QLD, 4014. Tel: 02 9701 4159, Fax: 02 9701 4350. Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

APPENDIX 6: Participant consent form (Focus Group)

I (the participant) of

..... (address)

(.....)..... (day-time phone number)

have read and understood the information provided in the Participant Information Letter. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity by attending a focus group, realising that I can withdraw at any time. This focus group will take approximately 60 minutes of your time. I understand that all information will remain confidential. By signing my name, I indicate that:

- I consent to the audio-taping of the focus group
- I consent to the collection, processing and reporting of my focus group data for healthcare/research purposes. All data will be de-identified, therefore not including my name, address or phone number. My information will be identified by a numerical random code.
- I understand that my unique study number will identify data from the focus group. This information is potentially identifiable but precautions will be taken by the research team to ensure the information will be kept confidential.

NAME OF PARTICIPANT (block)

Signature..... Date.....

Research team

Professor Sandy Middleton
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Dr Rhonda Hawley
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Ms Rose McMaster
School of Nursing (NSW & ACT)
Faculty of Health Sciences

APPENDIX 7: Information Letter to Participants

Dear Madam,

You are invited to participate in an interview to assist in the evaluation of [REDACTED] which is under the management of The Marmalade Foundation Limited. This interview will take approximately 40 – 60 minutes of your time and will take place at your convenience. The questions relate to your experience as a client within [REDACTED]. The demands of being a participant will include the time given to an interview. To re-imburse your time and participation, \$30 cash will be given to you.

The questionnaires which were completed when you first came to [REDACTED] and at three months will also be accessed by the researchers to help with demographic information, health status, accommodation options and the needs identified by you when you first came to Lou' Place.

This study is being conducted by Professor Sandy Middleton, Dr Rhonda Hawley and Rose McMaster from the School of Nursing (NSW & ACT), Faculty of Health Sciences, Australian Catholic University (ACU) National. The Human Research Ethics Committee at ACU National have approved this study. Participation is voluntary and, should you decide not to participate or to withdraw at any time, your decision will be respected and will not prejudice your present or future relationship with [REDACTED] or the management of The Marmalade Foundation Limited. All participants have been allocated a unique code number that will be used only to monitor the response rate. All information will be stored securely and archived in accordance with the National Health and Medical Research Council recommendations. Information obtained from this interview will eventuate in a research report and publications and no individual participants will be identified in these documents.

If you have any further questions, please contact Rose McMaster on (02) 9739 2369. This information sheet and a signed copy of the consent form is for you to keep. Results from this study will help inform staff involved in [REDACTED] and the Marmalade Foundation Limited about your experiences of being a client at [REDACTED]. We hope you will agree to participate.

Yours sincerely

Professor Sandy Middleton
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Dr Rhonda Hawley
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Ms Rose McMaster
School of Nursing (NSW & ACT)
Faculty of Health Sciences

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator has not been able to satisfy, you may write to the NSW & ACT Chair of the Human Research Ethics Committee (HREC), c/o Research Services, Australian Catholic University, North Sydney Campus, PO Box 968, NORTH SYDNEY NSW 2059. Tel: 02 9739 2105, Fax: 02 9739 2870. Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

APPENDIX 8: Participant Consent Form (Client)

PARTICIPANT CONSENT FORM - Client's copy

I (the participant) of

..... (address)

(..... (mobile phone number)

have read and understood the information provided in the Participant Information Letter. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity by participating in a face to face interview, realising that I can withdraw at any time without adverse consequences. This interview will take approximately 60 minutes and will take place at your convenience. I understand that all information will remain confidential. By signing my name, I indicate that:

- I consent to take part in an audio-taped interview.
- I will be re-imbursed \$30 for participating in this interview.
- I agree that the research team may access my clinical data from records held at [REDACTED]
- I consent to the collection, processing and reporting of my personal sensitive information for healthcare/research purposes. All data will be de-identified, therefore not including my name, address or phone number.
- I understand that the data collected for this study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT (block)

Signature..... Date.....

Professor Sandy Middleton
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Dr Rhonda Hawley
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Ms Rose McMaster
School of Nursing (NSW & ACT)
Faculty of Health Sciences

APPENDIX 9: Information Letter to Participants (HCP/Case managers)

Dear Colleague,

You are invited to participate in an interview to assist in the evaluation of [REDACTED] which is under the management of The Marmalade Foundation Limited. Questions relate to your experience as case manager or health provider working within [REDACTED]. This audio-taped interview will take place at your convenience, and last approximately 60 minutes. There are no perceived benefits or risks to you of being involved in this project but we hope the results will help inform [REDACTED] staff and management about their service.

This study is being conducted by Professor Sandy Middleton, Dr Rhonda Hawley and Rose McMaster (who is undertaking her PhD) from the School of Nursing (NSW & ACT), Faculty of Health Sciences, Australian Catholic University (ACU) National. The Human Research Ethics Committee at ACU National have approved this study. Participation is voluntary and, should you decide not to participate or to withdraw at any time, your decision will be respected and will not prejudice your present or future relationship with [REDACTED] or the management of The Marmalade Foundation Limited. All participants have been allocated a unique code number that will be used only to monitor the response rate. All interview data will be confidential and all data will be de-identified; therefore not include name, address or phone number. Only the research team will have access to this data.

All information will be stored securely and archived in accordance with the National Health and Medical Research Council recommendations. Information obtained from this study will eventuate in a research report and publications and no individual participants will be identified in these documents.

If you have any further questions, please contact Rose McMaster on (02) 9739 2369. This information sheet and a signed copy of the consent form is for you to keep. Results from this study will help inform staff involved in [REDACTED] and the management of The Marmalade Foundation Limited. We hope you will agree to participate. The attached consent form will be given to you after you have read the Information sheet and you agree to participate. One copy is for you to sign and keep and the other is for the researcher.

Yours sincerely

Principal Supervisor: Professor Sandy Middleton	Co-Supervisor: Dr Rhonda Hawley
School of Nursing (NSW & ACT)	School of Nursing (NSW & ACT)
Faculty of Health Sciences	Faculty of Health Sciences

Student Researcher: Ms Rose McMaster
School of Nursing (NSW & ACT)
Faculty of Health Sciences

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator has not been able to satisfy, you may write to the NSW & ACT Chair of the Human Research Ethics Committee (HREC), c/o Research Services, Australian Catholic University, North Sydney Campus, PO Box 968, NORTH SYDNEY NSW 2059. Tel: 02 9739 2105, Fax: 02 9739 2870. Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

APPENDIX 10: Consent Form (HCP/Case Managers)

PARTICIPANT CONSENT FORM - Participant's copy

I (the participant) of

..... (address)

(..... (mobile phone number)

have read and understood the information provided in the Participant Information Letter. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity by being interviewed, realising that I can withdraw at any time. This interview will take approximately 60 minutes of my time and will take place at my convenience. I understand that all information will remain confidential. By signing my name, I indicate that:

- I consent to take part in an audio-taped interview.
- I consent to the collection, processing and reporting of my personal sensitive information for healthcare/research purposes. All data will be de-identified, therefore not including my name, address or phone number. My information will be identified by a numerical code.
- I understand that the data collected for this study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT (block)

Signature..... Date.....

Professor Sandy Middleton
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Dr Rhonda Hawley
School of Nursing (NSW & ACT)
Faculty of Health Sciences

Ms Rose McMaster
School of Nursing (NSW & ACT)
Faculty of Health Sciences

APPENDIX 11: Semi-structured open ended interview schedule (Client)

Sample Questions:

1. Would you tell me of your experience of being a client in the Housing Support Program (HSP) with [REDACTED] (formally know as [REDACTED])?
2. Can you describe to me how your coordinator / case manager has helped you maintain your housing tenancy?
3. Can you describe any benefits to you of being part of this Program?
4. Can you identify any changes that you would want to see for people who need the HSP?
5. How could this service be improved?
6. Can you tell me about the other services that have been involved with the HSP?
7. How satisfied were you with the involvement with the other services?

APPENDIX 12: Semi-structured open ended interview schedule (Case Manager)

Sample Questions:

1. Would you tell me what it has been like to be a case manager within the Housing Support Program (HSP) with [REDACTED] (formally know as [REDACTED])?
2. Can you tell me why you became part of the HSP?
3. Can you tell me about your relationship with referral agencies to the HSP?
4. What have been some of the challenges of being a case manager in this Program?
5. Can you describe some of the benefits of being a case manager in this Program?
6. Can you identify any changes that you would want to see for case managers in the HSP?
7. Can you tell me about any limitations/barriers that you have come up against while working in the HSP?

APPENDIX 13: Focus group study

History

Mary is a 66 year old female who has a past history of non-insulin dependent diabetes and a clinical diagnosis of anxiety and agrophobia. She also has limited mobility due to arthritis which has contributed to her being house bound. She has no family within Australia. Dr M is the local GP who does not undertake home visits. Mary has not had any other contact with health providers or other professionals. She is not eating well, she takes her medication 'when she remembers' and tends little to her personal hygiene. She has limited contact with the outside world.

Provision of Services

Mary has been living in a Department of Housing accommodation by herself for the last four years. Following a routine fire safety inspection, it was revealed that Mary had a hoarding issue. Mary has been advised that she is at risk of losing her tenancy if she does not comply with inspection requests to reduce her belongings. Mary is very concerned about her finances and also about the possibility of being asked to leave her place of residence. She is anxious about losing her belongings and reluctant to consider removal of any items.

Referral Process

Because Mary is at high risk of losing her tenancy, you consider referring her to the Housing Support Program (HSP) [REDACTED]

1. Discuss why you would /would not refer Mary to the Housing Support Program.
2. Within your current role, what would be some of the difficulties you may encounter when referring Mary to the Housing Support Program?
3. In your experience, what would be the major benefits of referring Mary to the Housing Support Program?
4. What outcomes would you expect for Mary after you have referred her to the Housing Support Program?

APPENDIX 14: Focus Group

General questions for discussion

1. Can you tell me what management strategies you would have employed for clients at risk of loss of tenancy prior to the establishment of the HSP?
2. The Housing Support Program is a pilot program, can you identify some of the reasons why the HSP was required?
3. Could you describe the most important goals of the HSP for clients at risk of loss of tenancy?
4. What are some of the critical actions/management strategies that the HSP undertake that allows it to achieve the above goals for clients?
5. What do you see as the barriers when referring clients to HSP?
If the HSP was not available, can you tell us what would happen to the clients at risk of loss of tenancy?
6. What recommendations would you make to improve the referral process and quality of the service provided by the Housing Support Program?
7. Can you tell us what other benefits, besides maintaining tenancy, there are for clients referred to the HSP?

APPENDIX 15: Interview/Question Schedule (Client)

Sample Questions:

1. Would you tell me of your experience of being a client at [REDACTED] over the last three months?
2. Can you describe to me how your case manager has helped you in your areas of need?
3. Can you tell me about the services that you have been involved with at [REDACTED]?
4. How satisfied were you with the services at [REDACTED]?
5. Can you tell me about the activities that you have been involved with at [REDACTED]?
6. How satisfied were you with the activities at [REDACTED]?
7. Can you describe any benefits to you of being at [REDACTED]?
8. Can you identify any changes that you would want to see for people who need to use the services at [REDACTED]?
9. How could this service be improved?
10. How satisfied are you at present with your
 - standard of living
 - own health
 - achievements in life
 - personal relationships
 - feeling safe
 - feeling part of the community
 - future security
 - support from others

APPENDIX 16: Interview/Question Schedule (HCP/Case Manager)

Sample Questions:

1. Would you tell me what it has been like to be a case manager or health provider at [REDACTED]?
2. What is involved in the type of work you undertake at [REDACTED]?
3. Can you tell me why you became a case manager or health provider at [REDACTED]?
4. Can you tell me about your relationship with referral agencies with clients at [REDACTED]?
5. What have been some of the challenges of being a case manager or health provider at [REDACTED]?
6. Can you describe some of the benefits of being a case manager or health provider at [REDACTED]?
7. Can you identify any changes that you would want to see for case managers or health provider at [REDACTED]?
8. Can you tell me about any limitations/barriers that you have come up against while working at [REDACTED]?
9. Overall, what is your impression of the services provide for the women at [REDACTED]?

APPENDIX 17: Ethics approval HSP

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Professor Sandy Middleton Nth Sydney Campus
Co-Investigators: Dr Rhonda Hawley Nth Sydney Campus
Student Researcher: Ms Rose McMaster Nth Sydney Campus

Ethics approval has been granted for the following project:

Housing Support Program

for the period: 18 September 2008 to 31 January 2009

Human Research Ethics Committee (HREC) Register Number: N200708 59

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (2007) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: _____ Date: 18 September 2008
(Research Services Officer, McAuley Campus)

(Committee Approval.dot @21/11/2007)

Page 1 of 1

APPENDIX 18: Ethics approval MSP



Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Professor Sandy Middleton Nth Sydney Campus

Co-Investigators:

Student Researcher: Ms Rose McMaster Nth Sydney Campus

Ethics approval has been granted for the following project:

██████████ a daytime drop-in support
centre for women at risk of homelessness

for the period: 14 February 2011 to 31 July 2011

Human Research Ethics Committee (HREC) Register Number: N2010 66

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (2007) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

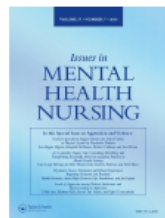
If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed.

..... Date: 14.02.2011
(Research Services Officer, McAuley Campus)

APPENDIX 19: Manuscript 1

Title: A qualitative study of a Maintenance Support Program for women at risk of homelessness: Part 1: Personal factors



Issues in Mental Health Nursing



ISSN: 0161-2840 (Print) 1096-4673 (Online) Journal homepage: <http://www.tandfonline.com/loi/imhn20>

A Qualitative Study of a Maintenance Support Program for Women at Risk of Homelessness: Part 1: Personal Factors

Rose McMaster RN, PhD Candidate, Violeta Lopez RN, PhD, Rachel Kornhaber RN, PhD & Michelle Cleary RN, PhD

To cite this article: Rose McMaster RN, PhD Candidate, Violeta Lopez RN, PhD, Rachel Kornhaber RN, PhD & Michelle Cleary RN, PhD (2017): A Qualitative Study of a Maintenance Support Program for Women at Risk of Homelessness: Part 1: Personal Factors, Issues in Mental Health Nursing

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APPENDIX 20: Manuscript 2

Title: A qualitative study of a Maintenance Support Program for women at risk of homelessness: Part 2: Situational factors



Issues in Mental Health Nursing



ISSN: 0161-2840 (Print) 1096-4673 (Online) Journal homepage: <http://www.tandfonline.com/loi/imhn20>

A Qualitative Study of a Maintenance Support Program for Women at Risk of Homelessness: Part 2: Situational Factors

Rose McMaster RN, PhD Candidate, Violeta Lopez RN, PhD, Rachel Kornhaber RN, PhD & Michelle Cleary RN, PhD

To cite this article: Rose McMaster RN, PhD Candidate, Violeta Lopez RN, PhD, Rachel Kornhaber RN, PhD & Michelle Cleary RN, PhD (2017): A Qualitative Study of a Maintenance Support Program for Women at Risk of Homelessness: Part 2: Situational Factors, *Issues in Mental Health Nursing*

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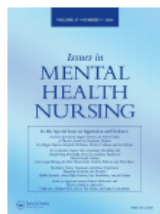
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Date: 28 March 2017, At: 12:42

APPENDIX 21: Manuscript 3

Title: A qualitative study of a Maintenance Support Program for women at risk of homelessness: Part 3: Societal factors



Issues in Mental Health Nursing



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A Qualitative Study of a Maintenance Support Program for Women at Risk of Homelessness: Part 3: Societal Factors

Rose McMaster RN, PhD Candidate, Violeta Lopez RN, PhD, Rachel Kornhaber RN, PhD & Michelle Cleary RN, PhD

To cite this article: Rose McMaster RN, PhD Candidate, Violeta Lopez RN, PhD, Rachel Kornhaber RN, PhD & Michelle Cleary RN, PhD (2017): A Qualitative Study of a Maintenance Support Program for Women at Risk of Homelessness: Part 3: Societal Factors, Issues in Mental Health Nursing

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APPENDIX 22: Statement of Co-Authorship



Graduate Research Office
Private Bag 1, Hobart, Tasmania 7001
301 Sandy Bay Rd, Sandy Bay
Tel: 03 6226 8559 Email: Graduate.Research@utas.edu.au

Statement of Co-Authorship

IMPORTANT INFO

Where the candidate has co-authored a published paper that is included in the body of the text or is included in whole or in part in the appendix, a statement of authorship should be prepared by the candidate's supervisors for inclusion in the thesis. This statement must be signed by the primary supervisor and attest to the contribution of the candidate and the co-authors.

There are two template co-authorship statements below:

1. To be signed by all authors and this is forwarded to the school.

Please send to Graduate Research Office, who will pass on to your school.

2. To be signed by the Supervisor and Head of School only.

This statement is to be included in the thesis.

Statement of Co-Authorship

The following people and institutions contributed to the publication of the work undertaken as part of this thesis:

Candidate: Rose McMaster (RMc), School of Health Sciences, UTaS
Michelle Cleary (MC), School of Health Sciences, UTaS
Violeta Lopez (VL), National University of Singapore
Rachel Kornhaber (RK), School of Health Sciences, UTaS

Author details and their roles:

Appendix 19

Publication details: McMaster, R., Lopez, V., Kornhaber, R. & Cleary, M. (in press, 2017). A qualitative study of a Maintenance Support Program for women at risk of homelessness: Part 1: Personal factors. *Issues in Mental Health Nursing*. Accepted 5 February 2017.

Authors' contributions: RMc designed the study, collected and analysed data and drafted the manuscript. MC and VL were involved in the study design, analysis and manuscript preparation. RK was also involved in manuscript preparation. RMc drafted the responses to the reviewers' comments.

Appendix 20

Publication details: McMaster, R., Lopez, V., Kornhaber, R. & Cleary, M. (in press, 2017). A qualitative study of a Maintenance Support Program for women at risk of homelessness: Part 2: Situational factors. *Issues in Mental Health Nursing*. Accepted 5 February 2017.

Authors' contributions: RMc designed the study, collected and analysed data and drafted the manuscript. MC and VL were involved in the study design, analysis and manuscript preparation. RK was also involved in manuscript preparation. RMc drafted the responses to the reviewers' comments.

Appendix 21

Publication details: McMaster, R., Lopez, V., Kornhaber, R. & Cleary, M. (in press, 2017). A qualitative study of a Maintenance Support Program for women at risk of homelessness: Part 3 Societal factors. *Issues in Mental Health Nursing*. Accepted 5 February 2017.

Authors' contributions: RMc designed the study, collected and analysed data and drafted the manuscript. MC and VL were involved in the study design, analysis and manuscript preparation. RK was also involved in manuscript preparation. RMc drafted the responses to the reviewers' comments.

We the undersigned agree with the above stated "proportion of work undertaken" for each of the above published (or submitted) peer-reviewed manuscripts contributing to this thesis:

Signed: Candidate

MC

VL

RK

Date: 8th February 2017

Statement of Co-Authorship

The following people and institutions contributed to the publication of work undertaken as part of this thesis:

Candidate: Rose McMaster (RMc), School of Health Sciences, UTaS
Michelle Cleary (MC), School of Health Sciences, UTaS
Violeta Lopez (VL), National University of Singapore
Rachel Kornhaber (RK), School of Health Sciences, UTaS

Author details and their roles:

Appendix 19

Publication details: McMaster, R., Lopez, V., Kornhaber, R. & Cleary, M. (in press, 2017). A qualitative study of a Maintenance Support Program for women at risk of homelessness: Part 1: Personal factors. *Issues in Mental Health Nursing*. Accepted 5 February 2017.

Authors' contributions: RMc designed the study, collected and analysed data and drafted the manuscript. MC and VL were involved in the study design, analysis and manuscript preparation. RK was also involved in manuscript preparation. RMc drafted the responses to the reviewers' comments.

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We the undersigned agree with the above stated "proportion of work undertaken" for each of the above published (or submitted) peer-reviewed manuscripts contributing to this thesis:

Signed:

Professor Michelle Cleary
Supervisor
School Of Health Sciences
University of Tasmania

Head of School
School of Health Sciences
University of Tasmania

Date: 8 February 2017

8 February 2017